United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

August 26, 2025

Mr. Jim Shaheen
Chief Executive Officer
New Season
2500 Maitland Center Pkwy. Suite 250
Maitland, FL 32751

Dear Mr. Shaheen:

I am writing to request information about access to methadone through opioid treatment programs (OTPs) in New Hampshire. Drug overdoses killed around 105,000 Americans in 2023 — and more than 400 New Hampshire residents — yet only 25 percent of Americans with opioid addiction receive medication assisted treatment (MAT), the gold standard for opioid addiction treatment.[1] Barriers to access for MAT, including methadone, may contribute to these outcomes, as current rules require patients who receive methadone to physically travel to OTPs, often daily. For-profit OTP owners argue that this system helps patients by promoting individualized therapy and counseling.[2] Yet some of these same companies have allegedly defrauded the government

[1] Trust for America's Health, *Pain in the Nation: The Epidemics of Alcohol, Drug, and Suicide; Special Feature: Progress in Drug Overdose Deaths* (May 2025) (www.tfah.org/report-details/pain-in-the-nation-2025/); Deborah Dowell et al., "Treatment for Opioid Use Disorder: Population Estimates - United States, 2022," *CDC Morbidity and Mortality Weekly Report* (June 27, 2024) (pubmed.ncbi.nlm.nih.gov/38935567/); Assistant Secretary Elinore F. McCance-Katz, Forward to *Facing Addiction in the United States: The Surgeon General's Spotlight on Opioids*, U.S. Department of Health and Human Services (Sept. 2018) (www.hhs.gov/sites/default/files/OC_SpotlightOnOpioids.pdf).

[2] Letter from Mr. Christopher H. Hunter, CEO of Acadia Healthcare, to Senators Edward J. Markey, Mike Braun, Maggie Hassan, and Elizabeth Warren, and Representatives Donald Norcross and Don Bacon (Apr. 12, 2024) (www.markey.senate.gov/imo/media/doc/acadia_response_41224.pdf).

and neglected their patients by billing Medicare and Medicaid for inadequate or even non-existent therapy or counseling.[3]

Experts agree that methadone, when taken consistently and as prescribed, is a highly effective form of MAT, given its unique efficacy in decreasing the likelihood of relapse.[4] However, unlike with other medications used for MAT, doctors must prescribe, and patients must usually consume, methadone at an OTP.[5] Studies show that travel time and distance to an OTP — even a distance of around five miles — can reduce patient retention in treatment.[6] In rural states like New Hampshire, the distance between patients and the nearest OTP can require a two-hour drive.[7] Reporting also suggests that some OTPs "rely on controlling and punitive strategies that make it harder, not easier, for patients to maintain their recovery."[8] These practices, together with the limitations and restrictions inherent to the OTP model, mean that "people who use drugs are often driven away from methadone treatment or never seek it in the first place."[9]

Large for-profit OTP companies have generally opposed proposals — such as allowing qualified physicians to prescribe methadone outside of an OTP — that would address barriers that limit access to methadone treatment. Industry representatives have argued that requiring patients to go to OTPs for methadone promotes the provision of essential therapy and

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[3] Katie Thomas and Jessica Silver-Greenberg, *Fraud and Fakery at the Country's Largest Chain of Methadone Clinics*, The New York Times (Dec. 7, 2024) (www.nytimes.com/2024/12/07/health/acadia-methadone-clinics-fraud.html).

[4] National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Sciences Policy; Committee on Medication-Assisted Treatment for Opioid Use Disorder, *Medications for Opioid Use Disorder Save Lives; The Effectiveness of Medication-Based Treatment for Opioid Use Disorder* (Mar. 30, 2019) (www.ncbi.nlm.nih.gov/books/NBK541393/).

[5] *Id.*

[6] Megan S. O'Grady et al., *Cumulative Barriers to Retention in Methadone Treatment Among Adults from Small Urban and Rural Communities*, Journal of Substance Abuse Treatment (July 2022) (www.ncbi.nlm.nih.gov/pmc/articles/PMC9284487/); Vanessa I. Villamil et al., *Barriers to Retention in Medications for Opioid Use Disorder Treatment in Real-World Practice,* Journal of Substance Use and Addiction Treatment (May 2024) (doi.org/10.1016/j.josat.2024.209310).

[7] Robert A. Kleinman*, Comparison of Driving Times to Opioid Treatment Programs and Pharmacies in the US*, JAMA Psychiatry (July 15, 2020) (pmc.ncbi.nlm.nih.gov/articles/PMC7364344/).

[8] Lev Facher, *Rigid Rules at Methadone Clinics are Jeopardizing Patients' Path to Recovery from Opioid Addiction*, STAT News (Mar. 12, 2024) (www.statnews.com/2024/03/12/methadone-clinics-rigid-rules-opioid-addiction-recovery/).

[9] *Id.*

counseling.[10] "All of the evidence for the safety and efficacy emanates from methadone treatment delivered…with physicians, nurses, and counselors working together to provide whole of person care," wrote the then-CEO of BayMark Health Services (BayMark) in a 2024 letter to Congress.[11] Similarly, the CEO of Acadia Healthcare (Acadia) wrote that the effectiveness of the OTP model rests on "[c]omprehensiveness, including the combination of medication-assisted treatment with integrated individual therapy, group counseling, and coordination of treatment with other medical and psychological needs."[12]

For-profit OTPs, however, have a financial incentive to maintain the status quo. After Medicare and Medicaid began covering methadone in 2020, OTP profits at Acadia, the largest OTP operator in the United States, increased 30 percent.[13] Acadia's 165 OTPs have generated $1.3 billion in revenue since 2022.[14] Most other OTPs are operated by for-profit companies, including private equity firms that, despite earning a large amount of revenue from taxpayer-funded insurance programs such as Medicaid, do not make financial information public and have typically declined to discuss their work on the record.[15] However, industry analysts state that an individual OTP with just 100 patients can generate up to $6.5 million in revenue annually.[16]

In addition, some for-profit OTP companies appear to systematically ignore the requirements that they claim to support. OTPs owned by these companies have allegedly falsified patient mental health records and engaged in other misconduct that enabled them to fraudulently bill insurance and increase revenue. For example, a whistleblower lawsuit from a former assistant medical director of an OTP in North Carolina alleges that Acadia systematically falsified records for at least a year beginning in September 2020, fabricating notes for certain

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[10] Opponents have also argued that allowing physicians to prescribe methadone outside of an OTP setting increases the risk of illegal diversion. In a 2024 rulemaking, however, SAMSHA noted that "[s]tate authorities reported that [COVID-19 era take-home] flexibilities were appreciated by patients and [providers] alike, with no significant change in rates of diversion seen since the COVID-19 [public health emergency] was declared." *See Medications for the Treatment of Opioid Use Disorder*, 89 Fed. Reg. 7528 (Feb. 2, 2024) (codified at 42 C.F.R. § 8).

[11] Letter from Mr. David K. White, CEO of BayMark Health Services, to Senators Edward J. Markey, Mike Braun, Maggie Hassan, and Elizabeth Warren and Representatives Donald Norcross and Don Bacon (Apr. 12, 2024).

[12] Acadia, *supra* note 2.

[13] New York Times, *supra* note 3.

[14] *Id*.

[15] Lev Facher, *Private Equity Moves into the Methadone Clinic Monopoly*, STAT News (Mar. 19, 2024) (www.statnews.com/2024/03/19/methadone-clinics-opioid-addiction-private-equity/).

[16] Julie Kniceley, *Exploring the Profitability of Methadone Clinics: A Comprehensive Analysis*, Strategique Partners (Mar. 2024) (www.strategiquepartners.com/exploring-the-profitability-of-methadone-clinics-a-comprehensive-analysis/).

therapy sessions in their entirety.[17] This is consistent with more recent reporting by the *New York Times*, which found that Acadia "employees in 17 states said supervisors and peers had taught them to cut corners by recycling old language from therapy notes or treatment plans without meeting with patients."[18]

BayMark, the second largest OTP operator in the United States, has faced similar allegations. During the pandemic, the federal government gave OTPs additional flexibility to provide patients with take-home doses — up to four weeks of medication in many cases. A lawsuit by a former director of a Georgia OTP, however, alleged that in late 2021, the company without explanation began requiring its Medicare and Medicaid patients — and *only* those patients — to return to the clinic on a weekly basis.[19] This allowed the OTP to bill the government for as many as three additional visits per month, even though "patients generally [did] not receive any additional treatment" besides filling their prescriptions.[20] The plaintiff ultimately agreed to dismiss her case, but her allegations are consistent with accounts from industry veterans. "During Covid, we gave a lot of take-homes, and we lost a lot of money doing it," Nick Stavros, the CEO of Community Medical Services, told *STAT News.*[21] "The providers who did the right thing were punished, and the providers who did the wrong thing profited."[22]

The Subcommittee seeks to better understand the impact of the OTP model on patient access to methadone; patient treatment outcomes; and potential waste, fraud, and abuse in federal health care programs. Given the variation in OTP regulations and Medicaid billing practices across states, the Subcommittee presently seeks information specific to OTPs in New Hampshire and requests responses no later than September 16, 2025.

From January 1, 2024, through March 31, 2025, please provide data about methadone MAT provided by OTPs at each of the facilities listed in Schedule A, broken down by month:

1) Total revenue;

2) Revenue from services to clients as defined by He-A 304 of the New Hampshire Code of Administrative Rules, broken down by Healthcare Common Procedure Coding System code, and showing the total count of claims per code, including:
    a. G2067;

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[17] *Complaint,* Sept. 13, 2021, *Wheeler v. Acadia Healthcare Co., Inc.*, No. 1:21-cv-00241 (W.D. N.C.).

[18] New York Times, *supra* note 3.

[19] *Complaint*, Jan. 31, 2022, *United States of America, et al. v. BayMark Health Services, Inc., et al.*, No. 4:22-CV-00029 (N.D. Ga.).

[20] *Id.*

[21] Facher, *supra* note 15.

[22] *Id.*

b. G2074;
c. G2076;
d. G2077;
e. G2078;
f. G2080; and
g. H0020;

3) Total number of clients by primary payer, including:
   a. Medicare;
   b. Medicaid;
   c. Private insurance;
   d. Cash payment; and
   e. Other;

4) Total number of new clients, broken down by:
   a. Clients previously discharged from the OTP; and
   b. Clients not previously discharged from the OTP;

5) For all new clients, the average time between intake and treatment as recorded pursuant to He-A 304.18 of the New Hampshire Code of Administrative Rules, including:
   a. Average time between initial contact date and intake date;
   b. Average time between initial contact date and first doses provided to client; and
   c. Average time between intake date and first doses provided to client;

6) Revenue from services to clients by payer, including the total count of clients per payer;

7) Average revenue per client;

8) The number of new employees and contractors hired, and the number of such individuals in full-time equivalent positions;

9) Average hours of counseling per client for all clients as of the first day of each month, broken down by:
   a. Individual;
   b. Family; and
   c. Group;

10) Average hours of counseling per patient for all patients enrolled in treatment as of the first day of each month, broken down by:
   a. Telehealth; and
   b. Non-telehealth;

11) The number of clients discharged, broken down by the reason for discharge, pursuant to He-A 304.28 of the New Hampshire Code of Administrative Rules, including:
    a. Program completion or transfer based on changes in the client's functioning relative to American Society of Addiction Medicine Criteria;
    b. Program termination, including:
        i. Administrative discharge;
        ii. The client left the program before completion against advice of treatment staff; and
        iii. The client is inaccessible, such as the client has been jailed or hospitalized;
    c. Other or unknown;

12) The number of clients administratively discharged and the reason for administrative discharge under He-A 304.28(b) of the New Hampshire Code of Administrative Rules;

13) The number of incidents of unethical conduct reported under He-A 304.12(u) of the New Hampshire Code of Administrative Rules;

Additionally, from January 1, 2024, through March 31, 2025, please provide data about methadone MAT provided by OTPs at each of the facilities listed in Schedule A, as of the first day of each quarter:

1) The number of full-time equivalent staff, broken down by:
    a. Licensed practitioners;
    b. Licensed counselors;
    c. Licensed supervisors;
    d. Unlicensed staff providing treatment, education, and/or recovery support services under the direct supervision of a licensed supervisor;
    e. Administrative staff; and
    f. Other;

2) The number of employees or contractors licensed to prescribe methadone, including the number of such employees or contractors with full-time equivalent positions;

3) The number of clients per licensed counselor and number of unlicensed staff supervised by each licensed counselor;

Additionally, for OTPs at each of the facilities listed in Schedule A, please provide:

1) The number of new, unique clients admitted between January 1, 2024, and October 1, 2024, and the number of such clients in treatment:
    a. 30 days from the date of intake date;
    b. 60 days from the date of intake date; and
    c. 90 days from the date of intake date;

2) For the specific dates of March 1, 2024, and February 28, 2025, the total count of clients:
   a. Not allowed methadone take-home doses;
   b. Receiving 1-day methadone take-home doses;
   c. Receiving 2-day methadone take-home doses;
   d. Receiving 3-day methadone take-home doses;
   e. Receiving 4-day methadone take-home doses;
   f. Receiving 5-day methadone take-home doses;
   g. Receiving 6-day methadone take-home doses; and
   h. Receiving more than 6-day methadone take-home doses;

3) For the specific dates of March 1, 2024, and February 28, 2025, the total count of clients:
   a. With 8 hours of counseling required per month and 1-90 consecutive days in compliance with He-A 304.23(o)
   a. With 8 hours of counseling required per month and 91-180 consecutive days in compliance with He-A 304.23(o);
   b. With 8 hours of counseling required per month, but reduced to:
      i. 7 hours pursuant to He-A 304.23(p) of the New Hampshire Code of Administrative Rules;
      ii. 6 hours pursuant to He-A 304.23(p) of the New Hampshire Code of Administrative Rules;
      iii. 5 hours pursuant to He-A 304.23(p) of the New Hampshire Code of Administrative Rules; and
      iv. 4 hours pursuant to He-A 304.23(p) of the New Hampshire Code of Administrative Rules;
   c. With 6 hours of counseling required per month;
   d. With 4 hours of counseling required per month and 365-540 consecutive days in compliance with He-A 304.23(o);
   e. With 4 hours of counseling required per month and 541-730 consecutive days in compliance with He-A 304.23(o);
   f. With 2 hours of counseling required per month; and
   g. With 1 hour of counseling required per month; and

4) For the specific dates of March 1, 2024, and February 28, 2025, the total count of clients for whom case management services were substituted for a portion of required counseling pursuant to He-A 304.23(r) of the New Hampshire Code of Administrative Rules, broken down by number of consecutive days in compliance with He-A 304.23(o).

From January 1, 2024, to March 31, 2025, please provide the following documents for each facility listed in Schedule A:

1) All quarterly quality management reports required under He-A 304.19 of the New Hampshire Code of Administrative Rules; and

The most current version of the following documents for each facility listed in Schedule A:

1) OTP accreditation report from a Substance Abuse and Mental Health Services Administration-approved OTP accrediting body;

2) All Plans of Correction accepted or issued pursuant to He-A 304 of the New Hampshire Code of Administrative Rules;

3) Written policies for client rights and responsibilities required under He-A 304.12(v)(1) of the New Hampshire Code of Administrative Rules;

4) Written grievance policies and procedures for staff and clients required under He-A 304.12(v)(2) of the New Hampshire Code of Administrative Rules;

5) Written client medication policy required under He-A 304.12(v)(9) of the New Hampshire Code of Administrative Rules;

6) Written procedures related to quality assurance and quality improvement required under He-A 304.12(v)(13) of the New Hampshire Code of Administrative Rules;

7) Policies and procedures for employee performance appraisals; and

8) Audited income statement.

If you have any questions related to this request, please contact [redacted]. Please send any official correspondence relating to this request to [redacted].

Sincerely,

Margaret Wood Hassan
Ranking Member
Senate Finance Subcommittee on Health Care

cc: Todd Young
Chairman

Schedule A

1. Concord Metro Treatment Center, 100 Hall Street, Concord, NH
2. New Season Treatment Center – Franklin, 880 Central Street Suite 10, Franklin, NH
3. Manchester Metro Treatment Center, 228 Maple Street, Manchester, NH
4. New Season Treatment Center – Manchester West, 865 Second Street, Manchester, NH
5. Keene Metro Treatment Center, 1076 West Swanzey Rd., Swanzey, NH