American Society of Addiction Medicine

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Treat Addiction ● Save Lives

June 25, 2013

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CMS-1599-P, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation.

Dear Administrator Tavenner:

The American Society of Addiction Medicine (ASAM) is pleased to have the opportunity to comment on the Proposed Rule for the Medicare Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation (CMS-1599-P).

Established in 1954, ASAM represents nearly 3,000 physician members who specialize in the treatment and prevention of addiction and practice in a wide range of primary care and specialty care settings, including psychiatric hospitals, inpatient psychiatric units of general hospitals, and general hospital settings. As such, we feel uniquely qualified to comment on the provisions of this proposed rule that have the potential to increase incentives for substance use screening, treatment, and follow-up in hospital settings.

ASAM commends the proposed inclusion of two of The Joint Commission (TJC) substance use screening, treatment, and follow-up measures within the Inpatient Psychiatric Facilities Quality Reporting (IPFQR) Program. However, these measures (SUB-1 Alcohol Use Screening, and SUB-4 Alcohol & Drug Use: Assessing Status after Discharge) are part a set of four inpatient substance use screening, treatment and follow up measures developed and adopted by TJC and under current review by the National Quality Forum. The current CMS proposal does not include quality measures addressing brief intervention or treatment initiation, nor would it apply these measures to all hospital settings, as the Joint Commission designed the measures to be used. ASAM urges CMS to include all four TJC substance use measures in

both the IPFQR Program as well as in the general Hospital IPPS: screening, brief intervention, treatment initiation, and status-after-discharge.

ASAM applauds CMS for recognizing the clinical importance of routinely screening for risky and addictive use of alcohol in patients admitted to hospitals for psychiatric conditions. Roughly half of psychiatric inpatients have a primary or comorbid substance use disorder, or use alcohol or drugs in ways that substantially increase their risk of medical, social and employment consequences. Screening, treatment and post-discharge follow-up regarding substance use and addiction will promote good patient care in psychiatric inpatient services. Evidence-based screening instruments exist that can detect harmful alcohol and other drug use in this vulnerable population. Brief interventions that can be delivered during a single brief counseling session in the hospital have been tested in multiple randomized trials, including a multi-center one in the Medicare eligible age group.[1] They demonstrate that screening and intervention significantly reduce health risks, and generate cost-savings of approximately $4 dollars for every dollar invested in providing them.[2]

Substance use problems among Medicare beneficiaries are not uncommon. Among 12,000 older adults living in a California retirement community, 31% of men and 22% of women reported consuming an excessive amount of alcohol[3]. Another study conducted in community clinics found that 15% of men and 12% of women age 60 and older that used any alcohol drank at levels above the limits recommended by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). [4] Analysis of the 2008 National Survey on Drug Use and Health (NSDUH) finds that 27.3% of men 65 years (2,001,279 men) and older and 10.4% of older women (694,505 women) report drinking 5 or more drinks on at least one occasion within the previous 30 days, levels that exceed NIAAA recommended limits[5]. One older adult in fifteen (6.6%) reports heavy alcohol use on two or more occasions in the previous month.[6] Although a small proportion of older men and women meet diagnostic criteria for an alcohol use disorder (1.5% for men, 0.3% for women) [7], a much larger number of older Americans who use alcohol at unhealthy amounts that can dangerously interact with other medications that they take.

Few older adults use street drugs (only 0.1% of elderly in the 2009 NSDUH met criteria of a drug use disorder)[8]. However, as many as one in four older adults take psychoactive medications (i.e., sedative-hypnotics, anxiolytics, and narcotic-analgesics) that have high abuse potential, are frequently prescribed for common geriatric conditions (e.g., insomnia, anxiety, and chronic pain), and that interact dangerously with alcohol and other prescription drugs[9] . Analysis of the 2008 NSDUH shows that 8.2% of older men and 6.5% of older women report misusing prescription psychoactive medications[10]. Older individuals are more likely to experience adverse side effects from these medications, and their use can lead to significant drug interactions[11].

Alcohol and psychoactive substance use are associated increased the risk of hospitalization, nursing home placement and death among older adults[12]. A national study using Medicare hospital claims data found the rates of alcohol-related hospital admissions to be similar to admission rates for heart attacks.[13] A recent study of Medicare beneficiaries found that presence of heavy alcohol use more than doubles the risk of hip fractures[14]. Nightly use of benzodiazepines is associated with a significantly increased risk of falls among older adults, and other psychoactive medications (sedative-hypnotics, tranquilizers, and prescription analgesics) appear to also increase risk of falls in the elderly[15]. Hospitalized patients with a substance use disorder had more than twice the risk of 30 day readmission and 30 recurrent use of emergency department services than matched patients with no substance use disorder.[16]

Given the prevalence of risky alcohol and other substance use among Medicare beneficiaries and the costly consequences of such use, and the rates of undetected alcohol use disorder in Medicare patients who are hospitalized for a psychiatric reason, it is valuable and clinically relevant to include all four TJC substance use measures --screening, brief intervention, treatment initiation and follow-up within both the IPFQR as well as the general hospital IPPS. We advise that you specifically include measures SUB-2 and SUB-3, which measure brief intervention for psychiatric patients with unhealthy alcohol use, and initiation of treatment for patients with substance use disorders, as Inclusion of all four TJC measures in CMS's quality reporting and incentive payment programs can serve to promote proper screening, intervention, and treatment for Medicare beneficiaries at risk of substance use disorders and prevent costly complications and readmissions resulting from substance use.

In closing, the American Society of Addiction Medicine wants to emphasize its thanks to the Department for the opportunity to submit comments regarding this important issue. We look forward to a continued collaboration ways to advance and promote the best care for patients at risk of and suffering from substance use disorders.

Sincerely,

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Acting President, American Society of Addiction Medicine

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