American Society of Addiction Medicine

4601 North Park Avenue ● Upper Arcade Suite 101 ● Chevy Chase, MD 20815-4520
Treat Addiction ● Save Lives

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December 26, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: CMS-9980-P, Patient Protection and Affordable Care Act Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Dear Administrator Tavenner:

The American Society of Addiction Medicine (ASAM) is pleased to have the opportunity to comment on the Proposed Rule on the Affordable Care Act's (ACA) Essential Health Benefits (EHB).

Established in 1954, ASAM has nearly 3,000 members and chapters that cover 42 states. Our members specialize in the treatment of addiction and practice in a wide range of primary care and specialty care settings. As such, we feel uniquely qualified to comment on the provisions of this proposed rule that have the potential to increase patient access to mental health and substance use disorder treatment.

ASAM supports health care reform that ensures that all Americans, particularly the marginalized and vulnerable, have access to high quality, evidence-based, affordable addiction treatment. This includes care for the treatment of addiction and other health conditions related to the use of alcohol, nicotine and other drugs, and illicit use of prescription medications. At the most fundamental level, access to good health care relies upon access to qualified health care professionals. ASAM would like to comment, specifically, on the sections of this proposed rule that have a direct impact on a patient's access to a robust addiction and mental health benefit package.

A long history of insurance discrimination against those with substance use and mental health disorders (SUD/MH) has prevented many individuals from receiving the clinically appropriate care needed to get and stay well. There is also an unacceptably large treatment gap for SUD/MH. 19.3 million Americans were classified as needing treatment

Phone: (301) 656-3920 ● Fax: (301) 656-3815
E-mail: email@asam.org ● Website: www.asam.org

for a substance use disorder in 2011, but did not receive it.[1] The Affordable Care Act (ACA) holds tremendous promise for significantly reducing SUD/MH treatment gaps, but without a robust EHB and other protections to ensure access to medically necessary SUD and MH care this potential will go largely unfulfilled.

Access to addiction treatment also holds the potential to drive down costs overall. In the Medicaid program, 66% of frequent users of emergency department services have addictive disorders.[2]

SUD/MH disorders often present as co-occurring disorders along with other medical conditions, and individuals with multiple chronic conditions have been shown to have higher health care utilization rates and higher overall costs for their care. A Washington State studied the effect of access to SUD/MH treatment in their Medicaid program and found that:

- Medicaid costs were reduced by 5% ($4,500 less over a five-year follow up period).[3]
- Inpatient and emergency department costs declined by 39% following treatment.[4]
- Total medical costs per patient per month went from $431 to $200.[5]

KEY PROVISIONS IN THE PROPOSED RULE

- **Sections §147.150(a) and §156.115(a)(2) – Requirement to offer addiction and mental health benefits in and outside of the exchanges at parity is critical.** ASAM members applaud the rule's explicit recognition of the ACA's requirement that the EHB include addiction and mental health treatment services, and in a manner consistent with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA).

  The proposed rule is consistent with Congressional intent in its application of parity to non-grandfathered small group and individual plans in and outside of the exchanges. This provision is critical to create a level playing field in the insurance marketplace and to avoid adverse selection in the exchanges. The intent of Congress in passing the ACA was to extend the provisions of MH and SUD parity (in benefit levels, utilization review processes, and other dimensions of care delivery, care financing and care management) to types of plans even beyond those explicated in the 2008 MHPAEA legislation. We thank the Department for its clear recognition of these critically important ACA requirements.

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[1] Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-44, HHS Publication No. (SMA) 12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

[2] Mancuso D, Nordlund DJ, Felver B. Frequent emergency room visits signal substance abuse and mental illness. Washington State DHHS, Research and Data Analysis Division, Olympia, WA. Updated June 2004.

[3] Luchansky, Bill & Longhi, Dario, "Cost Savings in Medicaid Medical Expenses: An Outcome of Publically Funded Chemical Dependency Treatment in Washington State," Washington State Dept. of Social and Health Services, June 1997.

[4] Parthasarathy, S. et al. *Association of Outpatient Alcohol and Drug Treatment with Health Care Utilization and Cost: Revisiting the Offset Hypothesis* Division of Research, Kaiser Permanente Medical Program, 2001.

[5] Parthasarathy, S., et al., "Utilization and Cost Impact of Integrating Substance Abuse Treatment and Primary Care." *Medical Care*, 41(3):357-367, March 2003.

- **Section §155.170 - Inclusion of all state mandates that were in place in December 2011 in the essential health benefits package, regardless of the base benchmark option selected by the state.** Forty states have some form of addiction and mental health parity or mandated benefit laws, some of which provide stronger consumer protections than the federal law. It is critical that these protections remain in place.

PROPOSED MODIFICATIONS FOR INCLUSION IN A FINAL RULE

ASAM members respectfully offer the following 7 recommendations to the Department in response to the proposed rule. Our consideration of these issues is informed by our experiences with health insurance expenditures for SUD/MH, which have historically been at extremely low levels or nonexistent. The following is a summary of our recommendations for final EHB guidance for your consideration. We urge the Department to:

1. Implement a MHPAEA final rule, aggressively enforce MHPAEA on the federal level and provide specific guidance on MHPAEA implementation and enforcement to States to ensure meaningful implementation and enforcement. Section §156.115(a)(2)
2. Provide clear guidance on how states should supplement a mental health/addiction benefit category and ensure balance across or within categories. Sections §156.100(a), §156.110(b), §156.110(c)) and §156.110(e)
3. Include specific coverage for all FDA-approved medications for the treatment of substance use disorders. Section §156.120
4. Include maximum specificity on what services should be included in each category. Section §156.100(a)
5. Define federal standards for medical necessity and require disclosure of medical necessity criteria.
6. Ensure access to out-of-network addiction and mental health treatment. Section §156.130(c)
7. Require the use of the nationally recognized American Society of Addiction Medicine Patient Placement Criteria.

1. Recommendation: Implement a MHPAEA final rule, aggressively enforce MHPAEA on the federal level and provide specific guidance on MHPAEA implementation and enforcement to States to ensure meaningful implementation and enforcement.
Section §156.115(a)(2)

With the passage of MHPAEA in 2008, Congress sought to end the long history of insurance discrimination against those with SUD/MH that has prevented so many individuals from receiving the clinically appropriate type, level, and amount of care they need to get and stay well.

Although the MHPAEA regulations went into effect for all plans on January 1, 2011, plans, consumers and providers remain confused about how SUD/MH benefits should be designed and administered. Importantly, providers and consumers still experience inconsistent and discriminatory application of the law. One ASAM member reports that his practice regularly

encounters plans that require patients to be suicidal before they become eligible for SUD treatment, even when meeting nationally recognized patient placement criteria for an intensive level of care.

As the Department works to implement the EHB, it should recognize that there are still significant problems in implementation of existing parity regulations, and work to mitigate these issues in EHB regulations:

- Some plans are claiming to be parity compliant by providing sparse or single levels of inpatient services, sparse or very limited levels and types of outpatient services, and/or disproportionate restrictions on MH/SUD prescription drugs (e.g., “fail first” policies and/or restricted formularies). These cost-containment techniques appear to be applied more stringently with respect to SUD/MH benefits than to other medical benefits. These and other barriers to access are hurting individuals today and threaten to jeopardize access to SUD/MH benefits for enrollees in plans subject to the EHB beginning in 2014. And while placing barriers to access for addiction treatment may seem to be "cost-saving" for health plans, the fact is that total health care costs go up when co-occurring addiction is not recognized early and treated effectively; the best way to save costs is to remove barriers to access to addiction care.
- Patients and providers are often unclear about how parity is being applied by plans, and plans often refuse to disclose the MH/SUD medical necessity criteria and/or the medical/surgical criteria used by the plan to make benefit determinations.
- Some states still assert that enforcing parity is solely a federal responsibility.

This year, ASAM, as part of the Parity Implementation Coalition, joined former Congressmen Patrick Kennedy and Jim Ramstad in hosting a series of field hearings on the implementation of MHPAEA across the country. At the field hearings, patients, physicians and other providers testified that while discriminatory quantitative limits such as higher co-pays and visit limits have been largely eliminated, patients are still finding discriminatory barriers to their addiction and mental health benefits. Just some of these examples include:

- A patient from Virginia testified about his plan requiring that he “fail first” at outpatient treatment before the plan would pay for inpatient addiction treatment. The plan did not have a similar requirement on its medical/surgical benefits.
- An ASAM physician from California testified about the barriers he and his colleagues encounter. He stated, “There are a seemingly endless number of obstacles that insurers utilize to evade providing mental health and substance use services. Roadblocks we face include vague medical necessity standards, lengthy approval processes that result in attrition, bureaucratic stonewalling of service requests, appeals processes that require an advanced degree to navigate and so on. I encounter these obstacles every day in my work.”

Unfortunately, MHPAEA compliance concerns are evident in the benchmark plans states have selected. Examples of non-compliance include:

- Annual limits on outpatient and inpatient mental health and addiction treatment visits when a comparable limit is not evident on the medical side.
- Exclusion of coverage for inpatient and residential substance use disorder treatment services when a full range of treatments for medical/surgical conditions is covered.

- Exclusion of coverage for partial hospitalization and/or intensive outpatient program addiction rehabilitation services when a full range of comparable treatments for medical/surgical conditions is covered (such as day treatment for pulmonary rehabilitation, cardiac rehabilitation, stroke rehabilitation, or spinal cord injury rehabilitation).
- Exclusions of coverage for pharmacotherapies for addiction.
- More stringent medical management on the addiction and mental health benefit than on the medical/surgical benefit; one plan required concurrent review for the addiction and mental health benefit without having a comparable requirement on the medical/surgical benefit.

To address these issues, we recommend that:

- the Department establish a clear process for how states can modify a plan to ensure parity compliance if it is not compliant today (please see Recommendation 3 for more details).
- the Department clarify that the term "treatment limitation" includes both quantitative and non-quantitative treatment limitations and includes limits on scope of service and duration of treatment.
- the final rule require full disclosure of benefit and medical management criteria from states and plans to ensure MHPAEA compliance in plans subject to the EHB.
- the final rule include language that clearly indicates to states that they have a responsibility to implement and enforce the MHPAEA and ACA's parity requirement in their state.
- the final rule ensure that EHB plans may not apply a financial requirement or treatment limitation, either quantitative or non-quantitative, to SUD/MH benefits in any classification, that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.
- the final rule ensure EHB plans may not apply separate cost sharing requirements or treatment limitations that are applicable only with respect to SUD/MH benefits.

2. **Recommendation: Provide clear guidance on how states should supplement an addiction/mental health benefit category which is not currently MHPAEA compliant and ensure balance across and within categories.** Sections §156.100(a), §156.110(b), §156.110(c)) and §156.110(e)

Provide guidance for supplementing benchmark categories

The rule establishes a process for how states may supplement their benchmark if an entire category is absent, but more guidance is required for states whose benchmark plan includes a category that is insufficient. The Department acknowledged that some plans may not be compliant in the "Guide to Reviewing Proposed State EHB Benchmark Plans" that was released with the rule, but did not lay out a process for modifying plans to bring them into compliance.

In providing this guidance, there must be greater clarity on what constitutes a full and robust benefit category. We are concerned that requiring only the provision of any benefit in a category to meet EHB compliance would be far too weak a threshold, violating §1302(b)(4) of

the ACA's instruction to the Secretary to ensure that the EHB reflects "an appropriate balance among the categories." For example, some states have asked if they offer a mental health benefit, but do not offer an addiction benefit, if they would have met the ACA's requirements. This conclusion would be inconsistent with Congressional intent and the Department must ensure states are not permitted to only offer mental health treatment and be considered compliant with the law. The Department should provide guidance on how it intends to ensure plans have balance across and within categories.

Unfortunately, unless plans are required to offer a full and robust benefit, the evidence suggests many will not. For example, in the absence of a MHPAEA scope of services requirement, plans are eliminating certain levels of care and limiting provider types to non-physicians. A Government Accountability Office (GAO) report released last June found an increase in the number of employers who are excluding specific treatments such as residential treatment while offering a full array of treatments for the medical/surgical benefit. For the 2011 or 2010 plan year, 39 of 96 plans (41%) reported excluding a treatment. In comparison, in 2008, 27 of 81 plans (33%) reported excluding a treatment.

We strongly urge the Department to require that the *benefits* in each category be medically appropriate and comprehensive. A full range of services--from screening and brief intervention for drugs and alcohol to treatment to recovery management supports--should be included as part of the essential benefit under the ACA, just as these services are covered for other chronic diseases. Plans should not be permitted to offer a robust benefit in other categories while offering a minimal benefit in the addiction category. As we review later in this letter (see Recommendation 7), widely accepted patient placement criteria should be used to determine medical appropriateness and levels of care. For example, the *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders-- Second Edition, Revised* (PPC-2R) of the American Society of Addiction Medicine (ASAM) is a nationally recognized tool by which practical and clinical determination of levels of care can be measured for substance use disorders services.[6] Currently, 29 states require the use of the PPC-2R by state-funded providers.[7] It is also widely used by providers and payers in the private and public sectors nation-wide. (A new edition of these Criteria is scheduled for publication in 2013).

We urge the Department to provide states with a process for supplementing their base-benchmarks to comply with the parity, non-discrimination, and other requirements of the law, and to explicitly clarify that constructing the state's EHB package in this way is not considered a state-benefit mandate and will not impact state funding requirements. We also urge the Department to provide the necessary oversight to ensure that the EHB packages in all states are compliant with these requirements.

Define state flexibility

We encourage the Department to define and delineate the extent of state flexibility to reduce any of the ten EHB categories—and to clearly require States to comply with the additional prohibitions under MHPAEA against uniquely limiting the SUD/MH benefit category. And it is necessary thereafter that the Department work to enforce these limits. HHS should annually review State benchmark proposals for comprehensiveness of each of the ten EHB categories and establish a process for states to supplement categories that fall short.

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[6] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Griffith JH, eds. *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, 2nd edition, revised*. Chevy Chase, MD: American Society of Addiction Medicine; 2001.

[7] National Association of State Alcohol and Drug Abuse Directors Report, Current State AOD Agency Practices Regarding the Use of Patient Placement Criteria (PPC) – An Update, 2006.

Provide additional information on state benchmarks.
In our research, we found it difficult, or even impossible, to access some of the benchmark plans selected by states. Absent this information, it is incredibly difficult to determine if the plan is complying with the requirements of the MHPAEA and the ACA. The Department should establish a transparent process and make all benchmark plans publicly available.

3. **Include specific coverage for all FDA-approved medications for the treatment of substance use disorders and alcohol/drug withdrawal syndromes.** Section §156.120

We strongly recommend the Department ensure individuals have access to the full continuum of FDA-approved addiction pharmacotherapies, at parity with the spectrum of available medical/surgical pharmacotherapies. Like other chronic diseases such as diabetes and hypertension, medical management of opioid, alcohol and tobacco addiction may include medications that are taken for varying periods, including prolonged periods. All FDA-approved medications for the treatment of opioid, alcohol and nicotine dependence and for the treatment of withdrawal should be specifically covered. In fact, the National Quality Forum (NQF) has issued guidelines recommending the combination of medications and psychosocial support as part of an integrated SUD treatment program.[8] When medications and psychosocial support are used for addiction treatment, they:

- Improve the patient's overall survival
- Improve patient retention in treatment
- Decrease heroin, alcohol and other drug use
- Decrease the transmission of HIV
- Decrease criminal activity
- Increase social functioning including employment and housing[9]
- Improve birth outcomes[10].

Rename the class "opioid antagonists"
We are concerned that by naming "opioid antagonists" as a class under "anti-addiction/substance abuse treatment agents" in the additional materials provided by HHS to accompany the proposed EHB rule, some categories of medications approved for the treatment of substance use disorders may be excluded from coverage. For example, scientifically and strictly speaking, buprenorphine is not an "antagonist," but is a "partial agonist."

Buprenorphine, buprenorphine/naloxone, methadone, naltrexone and extended-release injectable naltrexone are FDA-approved medications shown to be highly effective in the treatment of opioid addiction, a chronic, life-threatening disease that affects millions of Americans. As with most chronic diseases, however, opioid-addicted patients often require long-term medication maintenance to achieve optimal outcomes. The vast majority of patients who receive medication-assisted opioid treatment do recover and lead healthy and productive lives.

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[8] National Quality Forum Report, National Standards for the Treatment of Substance Use Conditions, 2007.
[9] **Alford DP, LaBelle C, Richardson JM,** O'Connell JJ, Hohl CA**, Cheng DM, Samet JH.** Treating homeless opioid dependent patients with buprenorphine in an office-based setting**.** J Gen Intern Med. 2007; 22:171-176**.**
[10] Strain EC, Stitzer ML. Methadone Treatment for Opioid Dependence. 1999.

Absent strong guidance from the Department requiring EHB plans to cover pharmacotherapies for the treatment of addiction, we are concerned these medications will not be covered. Several state Medicaid programs are currently considering budget proposals or regulatory changes that would limit patient access to medication-assisted opioid treatment therapies. Many more states have already implemented policy changes that have limited access to these important addiction treatment pharmacotherapies, such as by arbitrarily limiting the duration of treatment with a pharmacological therapy for addiction. These policies take different forms but often include arbitrary and *a priori* limitations on duration of pharmacological treatment--regardless of the clinical indications or clinical decisions of the treating physician. Access-limiting policies also include *a priori* dosage ceilings or requirements for prior authorization and/or other medical necessity requirements that stall or complicate efficient care and may well not be reflected in prior authorization or other medical necessity requirements in place for pharmacological treatment of other conditions.

Policies limiting a patient's access to these life-saving medications undoubtedly have very negative effects: rates of patient relapse and opioid overdose will likely increase, as will overdose-related emergency healthcare and hospitalization expenditures. Limited access to addiction treatment has also been highly correlated with increased costs related to criminal justice, social welfare and lost productivity. We strongly recommend the Department require EHB plans to cover a full range of FDA-approved medications for the treatment of addiction and withdrawal syndromes.

To ensure all appropriate, evidence-based pharmacotherapies are covered, ASAM proposes this alternative language: "Opioid Addiction Maintenance/Detoxification Medications: includes all drugs or combinations of drugs that have been approved, under the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act, for use in opioid maintenance or detoxification treatment." This would include opioid antagonist medications as well as other agents.

4. **Include maximum specificity on what services should be covered in each category.**
   Section §156.100(a)

Specificity in EHB packages is important for two major reasons. First, specificity is needed in order to ensure that consumers have access to a defined, consistent and understandable package of benefits under individual and group plans, both inside and outside of the Exchanges. The EHB as a standard benefit becomes meaningless to consumers if that package is so broadly defined that consumers cannot understand what services are guaranteed. Specificity is particularly important in benefit identification of SUD/MH benefits, as historically the scope of and access to SUD/MH benefits, which should be comparable to the scope of medical/surgical benefits, have been inappropriately limited by plans. The ACA included a separate category for SUD/MH benefits in order to attempt to redress the historic tendency to underserve this population and to ensure a comprehensive SUD/MH benefit in balance with the scope of other benefits.

Second, specificity is important in order to ensure that the benefits provided reflect the full continuum of care that is recognized as medically appropriate for any given medical need. Specificity does not require the listing of every treatment for every medical condition nor does it preclude medical management of that benefit; rather, it requires that categories in the continuum of care be identified with the specificity appropriate to that area of medical service.

The identified scope of benefits should be based on clinical evidence or nationally recognized standards of care or practice guidelines such as those developed separately by the National Quality Forum and the Department of Veterans Affairs and Department of Defense, provided that benefits are not limited where clinical evidence or practices are under-developed. For example, it is inadequate for the EHB supplementary materials released by HHS to list "outpatient services" because outpatient for SUD/MH includes two distinct and important categories of services, intensive outpatient and outpatient (these are described in the ASAM Criteria as Level II and Level I care, which includes descriptions of sublevels of such care), and no EHB plan should be permitted to exclude a clinically critical component of outpatient care. Thus, for SUD/MH benefits, specificity requires identification of the full scope of treatment categories generally provided under national clinical standards including inpatient hospital, crisis services (inpatient and outpatient), residential treatment, partial hospitalization, intensive outpatient, outpatient, detoxification (inpatient and ambulatory), pharmacotherapy and medication management, home health care, preventive care, and recovery support services.

5. Define federal standards for medical necessity & require disclosure.

While the proposed rule does not address medical necessity standards within the context of EHBs, the degree to which Americans enjoy full access to covered services within the ten EHB categories will depend, to a large degree, on the medical necessity and other medical management standards that plans use to determine whether a service is covered.

Few regulations address the definition of medical necessity: there is no federal definition, and only about one-third of states have any regulatory standards for medical necessity. Consequently, the definition of "medical necessity" is most commonly found in individual insurance contracts that are defined by the insurer and often not available to physicians and patients, and similarly to other clinicians and to family members interested in patients receiving the appropriate care for their health condition. As a result, the standard of medical necessity is most often controlled by the insurer, not the treating physician. Even when a clinical recommendation is consistent with professional clinical guidelines, the insurer may reject a prescribed treatment if it is inconsistent with other definitional elements such as relative cost, efficiency and effectiveness.

We are recommending a federally defined medical necessity standard, which is consistent with the findings of the Institute of Medicine's recent report, *Essential Health Benefits: Balancing Coverage and Cost,* released October 7, 2011. This report discusses a framework for HHS to address medical necessity within the essential health benefit, stating: "The committee believes that the concepts of individualizing care, ensuring value, and having medical necessity decisions strongly rooted in evidence should be reemphasized in any guidance on medical necessity. Inflexibility in the application of medical necessity, clinical policies, medical management, and limits without consideration of the circumstances of an individual case is undesirable and potentially discriminatory."

Enforce the requirement that plans disclose medical necessity criteria

In addition to defining medical necessity, medical necessity criteria must be made available upon request, consistent with MHPAEA's requirements. Additionally, plans may not be permitted to withhold this information until there is a denial. Without plan administrators and health insurance experts disclosing their medical necessity criteria in advance, and how those criteria are applied to make benefit determinations, plan participants or providers acting on their behalf are unable to determine whether a plan has provided SUD/MH services in the "comparable and no more stringent than" manner required by MHPAEA.

Despite MHPAEA sub-regulatory guidance, non-compliance with disclosure requests by consumers and providers remains the norm. Many plan administrators or insurers do not respond to these requests at all. Other plan administrators or insurers continue to state that MHPAEA and its Interim Final Regulation do not require disclosure. Others continue to maintain that their criteria are proprietary and cannot be released, despite the legal requirement to do so. In other cases, disclosure is made of the medical necessity criteria with respect to SUD/MH benefits, but not the comparable criteria used with respect to medical/surgical benefits. Yet other plans may release their medical necessity criteria, but only after they have issued an adverse benefit determination.

Even with an unambiguous requirement under the parity law for plans to provide medical necessity criteria and have them available for scrutiny "up front" by patients, families, treatment providers, and entities providing quality assurance and regulatory oversight, plans have been slow and resistant to provide their criteria, especially the criteria they use to make "medical benefit" determinations; without such disclosure, a complete parity compliance test (to assure that there is no substantial difference between med/surg and MH/SUD care management within plans) is difficult if not impossible. We encourage the Department to define federal standards for medical necessity under the EHB and reinforce that both the med/surg and SUD/MH medical necessity criteria be made available to providers and patients. Given that medical necessity definitions commonly used by insurers today often impede access to appropriate SUD/MH treatment, federal medical necessity standards for this category of the EHB are critically important.

6. Ensure access to out-of-network treatment. Section §156.130(c)

Unfortunately, years of limited reimbursement by managed care for addiction treatment has significantly reduced the number of providers available for patients. According to data from the Substance Abuse and Mental Health Services Administration (SAMHSA), in 1990, there were over 16,000 substance abuse treatment facilities in the country. Today, there are 13,330 programs, even though starting in 2014 nearly a third of the patients expected to receive coverage under the Affordable Care Act have a substance use disorder and will need access to addiction treatment. Between 2008 and 2011, 37.3% of individuals who felt they needed addiction treatment but did not receive it said they did not get treatment because they lacked health insurance and could not afford it.[11]

For individuals with substance use disorders, access to out-of-network care is critical and, in some states, often the only way for patients to receive access to effective addiction treatment. Unfortunately, access to specialists, especially for adolescents and older Americans, may be limited by plan networks. As such, a final EHB rule should clarify that if a plan makes out-of-network care available for medical conditions, it must also provide access to out-of-network care for addiction/mental health services in a "comparable and no more stringent" manner than for other medical conditions.

Additionally, we are concerned with the rule's proposal to allow plans to exclude cost sharing for benefits provided by an out-of-network provider from the annual limit on cost sharing and/or deductibles. We propose that if in-network providers are not available, patients should be able

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[11] Substance Abuse and Mental Health Services Administration, *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-44, HHS Publication No. (SMA)

to access out-of-network providers under the same cost-sharing terms and conditions as in-network providers.

7. Require use of national patient placement criteria.

Nationally accepted patient placement criteria should be incorporated to ensure individuals receive the optimal level of SUD/MH care for the amount of time that is deemed medically necessary. The *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders-- Second Edition, Revised* (PPC-2R) of the American Society of Addiction Medicine (ASAM) is a widely used tool in 29 states by which practical and clinical determination of substance use levels of care can be measured.[12] (A new edition of these Criteria is scheduled for publication in 2013). Plans must be required to use objective, consensus-based patient placement criteria for the placement of patients in the appropriate level of care and not just proprietary criteria developed by a plan or utilization review firm for use by that plan or firm and not available for review by outside parties. The effects of SUD/MH treatment are optimized when individual patients are matched with appropriate levels of care.[13]

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 on advances in and increased access to alcohol, nicotine, and other drug addiction treatment.

Sincerely,

Stuart Gitlow, MD, MBA, MPH, FAPA

Acting President, American Society of Addiction Medicine

[12] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Griffith JH, eds. *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, 2nd edition, revised*. Chevy Chase, MD: American Society of Addiction Medicine; 2001.

[13] Sheedy C. K., and Whitter M. (2009). Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research? HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.