American Society of Addiction Medicine

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

September 18, 2013

The Honorable Max Baucus
Chairman
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Senators Baucus and Hatch:

The American Society of Addiction Medicine (ASAM) thanks you for the opportunity to comment on how to improve the addiction and mental health system in the United States.

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. Please find below responses to the three questions posed by the Committee with a focus on areas in which ASAM feels uniquely qualified to comment.

1. What administrative and legislative barriers prevent Medicare and Medicaid recipients from obtaining the mental and behavioral health care they need?

Unfortunately, a long history of insurance discrimination against those with substance use and mental health disorders (SUD/MH) in the public and private sectors has prevented many individuals from receiving the clinically appropriate care needed to get and stay well. There is an unacceptably large treatment gap for substance use disorders - 23.1 million Americans were classified as needing treatment for a substance use disorder in 2012, but only 2.5 million received it (10.8% of those who needed treatment).[1]

Coordinating care between addiction treatment services and primary care services can yield benefits. From the patient's perspective, the benefits associated with linking medical care and substance use disorder services include:

- Facilitated access to substance use disorder treatment and primary care services

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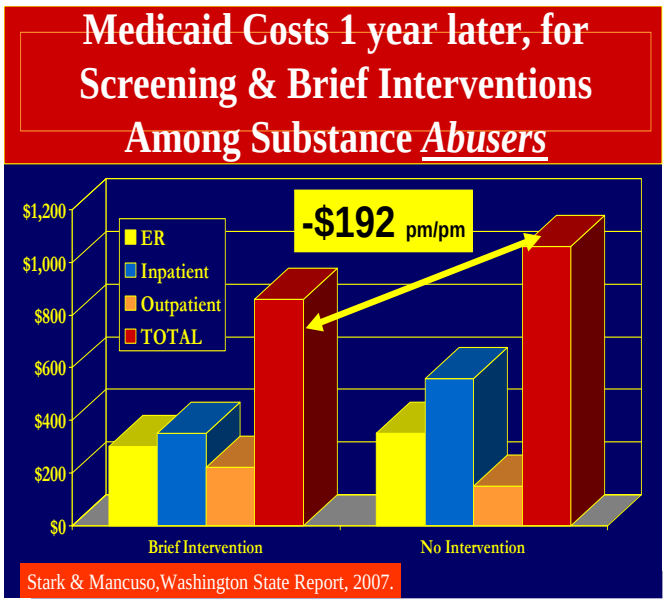
ance ental Health Services Administration, *Results from the 2012 National Survey on Drug ary of National Findings*, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Abuse and Mental Health Services Administration, 2013.

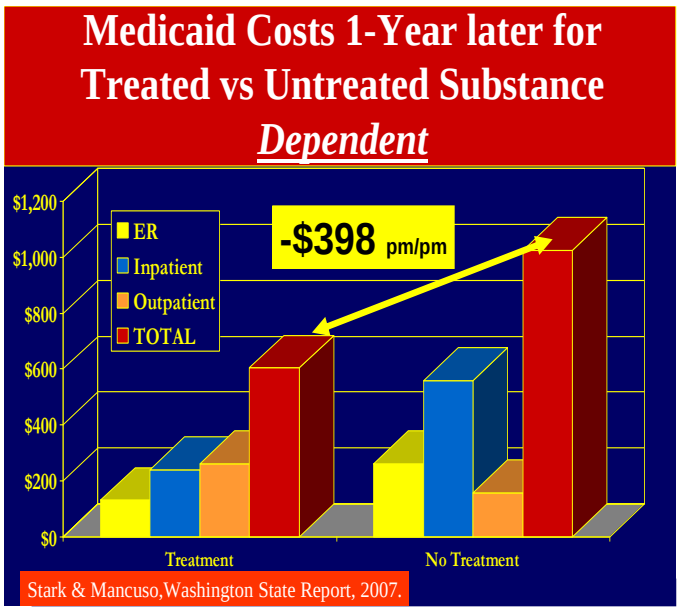
Phone: (301) 656-3920 ● Fax: (301) 656-3815
E-mail: email@asam.org ● Website: www.asam.org

- Decreased severity of substance use disorder and medical problems
- Increased patient satisfaction with health care[2]

From a societal or public health perspective, the potential benefits of linking the two include:

- Reduced health care costs
- Diminished duplication of services
- Improved health outcomes





Recent studies have demonstrated the cost savings associated with treatment. For example, a study of the Washington State Medicaid program on the effect of access to SUD/MH treatment 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]

With the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, Congress sought to end the long history of discrimination against those with MH and SUD needs in health insurance and Medicaid managed care. The Affordable Care Act (ACA) improved on MHPAEA by extending MH and SUD parity requirements to individual and small group health coverage and Medicaid alternative benefit plans, and by requiring coverage of MH and SUD services in these plans as essential

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[2] Samet JH, Friedmann P, Saitz R. Arch Intern Med. 2001; 161: 85-91.
[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.

health benefits. In January 2013, the Administration released guidance on the application of MHPAEA to Medicaid plans but final rules clarifying some of the grey areas existing in the parity law at large have not yet been released.

As a result of the lack of final guidance, plans, consumers and providers remain confused about how SUD/MH benefits should be designed and administered. Providers and consumers still experience inconsistent and discriminatory application of the law. Examples of some of these grey areas in the application of parity to Medicaid managed care and alternate benefit plans include:

Applicability of MHPAEA's Interim Final Rule (IFR) to Medicaid Alternate Benchmark Plans, Children's Health Insurance Plans (CHIP) and Medicaid Managed Care Organizations (MCOs). The January 16, 2013 guidance released by the Centers Medicare and Medicaid Services (CMS) states that MHPAEA's IFR is applicable to group health plans and health insurance issuers. However, while the guidance states that Medicaid Alternate Benchmark Plans, CHIP plans, and Medicaid MCOs must comply with MHPAEA, it does not explicitly state that the IFR also applies with respect to these entities. The guidance does, however, reference some, but not all, of the key terms and concepts set forth in the IFR, like financial requirements and treatment limitations (both quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs)).

Given these specific references, we are certain that CMS intended that the IFR applies to Medicaid Alternate Benchmark Plans, CHIP plans, and Medicaid MCOs. We are concerned though that the lack of a specific reference to the IFR may cause some Medicaid entities and/or health plans to speculate that the exact terms of the IFR, as codified at 45 CFR 146.136 et. al., do not apply to these Medicaid entities and plans and may fail to exact the necessary measures to ensure compliance. We have urged CMS to promptly clarify this issue through additional guidance by specifically stating that the IFR applies to Medicaid Alternate Benchmark Plans, CHIP plans, and Medicaid MCOs. Such guidance will eliminate any cause for speculation on this issue and improve compliance with the law and rules, thus ensuring access to SUD/MH services under the referenced Medicaid plans.

- **Additional Clarification Regarding Quantitative Treatment Limits and Non-Quantitative Treatment Limits to Medicaid Managed Care Organizations**. With respect to Medicaid MCOs, the January guidance states:

  "CMS will not find MCOs out of compliance with MHPAEA to the extent that the benefits offered by the MCO reflect the financial limitations, quantitative treatment limitations, nonquantitative treatment limitations, and disclosure requirements set forth in the Medicaid state plan and as specified in CMS approved contracts."

  We understand this to mean that Medicaid MCOs must comply with MHPAEA and its IFR in all cases, except where a state's traditional Medicaid plan specifically permits differential QTLs or NQTLs on coverage for SUD/MH benefits. Given the complexities of MHPAEA and the IFR and in an effort to avoid misinterpretations of the guidance, it would be helpful for CMS to promptly issue additional guidance with specific examples of how QTLs and/or NQTLs found within the state's traditional Medicaid plan will affect how a Medicaid MCO imposes treatment limitations on its MH/SUD benefits.

For example, with respect to QTLs, a traditional state Medicaid plan may place a 30-day limitation on inpatient mental health stays, but does not impose a similar limitation on medical/surgical inpatient stays. In this case, a Medicaid MCO may implement an identical policy (i.e., a 30-day limitation only on inpatient mental health stays) without running afoul of MHPAEA and the IFR. However, it is our understanding that, if there is no QTL explicitly defined in the state Medicaid plan, like the 30-day limit described above, the Medicaid MCO would not otherwise be able to implement other QTLs on MH/SUD benefits, unless they comply with the specific tests in the IFR.

Prompt clarification through additional guidance using these examples and others would be extremely helpful for Medicaid MCO plans and the plan participants to recognize and understand when MHPAEA and the IFR apply and when they can impose QTLs and NQTLs without analyzing compliance under MHPAEA and the IFR. Clarifications with respect to this issue will also increase compliance and ensure access to medically necessary care to MH/SUD patients.

- **Clarification Regarding MHPAEA's Rules on the 6 Benefits Classifications**. The IFR requires that if a health plan provides SUD/MH benefits in any of the 6 classifications of benefits identified by the IFR (i.e., inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency care; or prescription drugs), it must provide SUD/MH benefits in each classification for which the health plan provides medical/surgical benefits. Given that the guidance states that a Medicaid MCO must comply with MHPAEA with respect to benefits offered beyond those in the state traditional Medicaid plan, does this mean that if a Medicaid MCO provides exactly the benefits provided for in the state's traditional Medicaid plan, it does not need to meet the IFR's rules regarding the 6 classes of benefits? In other words, if a Medicaid MCO covers MH/SUD benefits in only 4 of the 6 classes of benefits, but covers medical/surgical benefits in 6 of the 6 classes of benefits, does this mean that the Medicaid MCO does not need to meet the IFR's rules regarding the 6 classes of benefits, as long as it provides coverage that is identical to the coverage provided by the state's traditional Medicaid plan?

- **Clarification Regarding MCO Benefit Design**. In addition to the questions above, we have also sought clarification on what the appropriate SUD/MH benefit design should be regarding Medicaid MCO plans, if the Medicaid MCO offers medical and surgical benefits beyond what is required by the State Medicaid plan. Specifically, given both Medicaid and MHPAEA rules, if an MCO offers a category of benefits for medical/surgical services that are not in the state traditional Medicaid plan, does the MCO have to provide the same services with respect to SUD/MH benefits?

  By way of example, assume a Medicaid MCO offers additional benefits for inpatient levels of care (beyond what is required in the traditional state Medicaid plan) for medical conditions such as skilled nursing care. In this case, will the Medicaid MCO also have to offer similar levels of care for intermediate/inpatient levels of care for MH/SUD, such as residential treatment for substance use disorders, even if this is not required in the traditional state plan or is an excluded benefit in the traditional state Medicaid plan?

  Also, for example, assume a Medicaid MCO offers benefits for home care for common medical/surgical conditions. If a Medicaid MCO offers home care for medical conditions even

though this benefit is not required by their contract with a state Medicaid agency, would these home care benefits have to also be available to SUD/MH conditions?

Examples of significant problems in implementation of existing parity regulations include:

- One ASAM member reports that his practice regularly encounters plans that require patients to be suicidal before they become eligible for SUD treatment, despite meeting nationally recognized patient placement criteria for an intensive level of care.
- Some plans are claiming to be parity compliant by providing sparse or single levels of inpatient services, facility type exclusions that are not imposed on other medical facilities, 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 covered under Medicaid managed care and may jeopardize access to SUD/MH benefits for Medicaid enrollees in alternate benefit plans. While placing barriers to access for addiction treatment may seem to be "cost-saving" for health plans, national studies have shown 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 that preclude 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 until a denial is made and withhold the medical/surgical criteria used by the plan to make benefit determinations so a parity compliance test can be performed. This is despite clear statutory requirements that medical necessity criteria be made available "upon request."

Unfortunately, MHPAEA compliance concerns are evident in the benchmark plans states selected for qualified health plans and we are concerned about similar problems arising in Medicaid alternative benefit plan benchmarks. 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 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).
- Exclusion of coverage for inpatient and residential substance use disorder treatment services when a full range of treatments and levels of care for medical/surgical conditions is covered.
- Exclusions or limitations of coverage for pharmacotherapies for addiction that are more stringent than limits on other pharmacotherapies.
- More stringent medical management on the addiction and mental health benefit than on the medical/surgical benefit; one plan required concurrent review for every visit for the addiction and mental health benefit without having a comparable requirement on the medical/surgical benefit.

While the actual benefits offered to consumers on the exchanges and through Medicaid expansion may correct some of these concerns, since many of the plan benefit summary documents have not been

publicly released by the states or the Administration, it is impossible to know if plans are complying with the law.

To address these barriers preventing access to care, we respectfully recommend Congress use its oversight authority to ensure:

- The expeditious release and implementation of the final MHPAEA regulations
- Plans being offered on the exchanges and to the Medicaid expansion benefit population cover mental health and addictive disorders at parity as intended by the ACA

2. What are the key policies that have led to improved outcomes for beneficiaries in programs that have tried integrated care models?

Primary care is an effective environment for the delivery of addiction treatment and primary care treatment improves outcomes. Receipt of two or more primary care visits lowers the odds of drug use or alcohol intoxication and decreased alcohol and drug use severity.[6]

Primary care teams comprised of physicians, nurses and case managers, are ideally positioned to support patients in and seeking recovery. Accountable Care Organizations (ACOs) and patient centered medical homes are beginning to show promising results in delivering integrated medical/behavioral health care. These integrated models are able to:

- Establish a supportive relationship with regular follow up
- Facilitate involvement in 12-step groups
- Help patients recognize and cope with relapse precipitants and craving
- Manage depression, anxiety and other co-occurring conditions
- Consider optimal use of pharmacotherapy
- Collaborate with addiction and mental health professionals[7,8]

3. How can Medicare and Medicaid be cost-effectively reformed to improve access to and quality of care for people with mental and behavioral health needs?

66% of the Medicaid population has addictive disorders and are frequent users of emergency department services.[9] ASAM members respectfully offer the following 3 recommendations to the Committee as recommendations for reforming Medicare and Medicaid and meeting the needs of these populations. 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 despite being significant drivers of emergency department visits and hospitalizations. We urge:

1. **Congress to use its oversight authority to encourage the Administration to release a MHPAEA final rule and aggressively enforce MHPAEA on the federal level. CMS must provide specific written guidance on MHPAEA implementation and enforcement to States**

[6] Saitz R, Horton NJ, Larson MJ, Winter M, Samet JH. Addiction. 2005; 100:70-78.
[7] Friedmann PD, Saitz R, Samet JH. JAMA. 1998;279:1227-1231.
[8] Friedmann PD, Rose J, Hayaki J, et al. J Gen Intern Med. 2006;21:1229-1275.
[9] 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.

to ensure meaningful implementation and enforcement. (please see above for more detail)

2. **We urge coverage of all FDA-approved medications for the treatment of substance use disorders by Medicare and Medicaid**. **CMS must avail Medicaid programs of the best evidence based practices in the pharmacologic treatment of addiction.** Individuals should 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.[10] 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 and Hepatitis C
    - Decrease criminal activity
    - Increase social functioning including employment and housing[11]
    - Improve birth outcomes[12].

    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.

    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. In June 2013, ASAM released a report on patient access to addiction medications. The study was conducted by researchers at the Avisa Group and Treatment Research Institute; the researchers surveyed all 50 state Medicaid programs and 30 private insurers and found a wide variety of policies

[10] National Quality Forum Report, National Standards for the Treatment of Substance Use Conditions, 2007.
[11] 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.
[12] Strain EC, Stitzer ML. Methadone Treatment for Opioid Dependence. 1999.

that amount to a de facto denial of coverage for approved addiction medications such as methadone, buprenorphine and naltrexone.

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 Medicare and Medicaid cover a full range of FDA-approved medications for the treatment of addiction and withdrawal syndromes.

3. **Require the use of the nationally recognized American Society of Addiction Medicine Patient Placement Criteria by Medicare and Medicaid**. Nationally accepted patient placement criteria should be incorporated into the Medicare and Medicaid programs to ensure individuals receive the optimal level of SUD/MH care for the amount of time that is deemed medically necessary. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*of the American Society of Addiction Medicine (ASAM) is a widely used tool in over 30 states by which practical and clinical determination of substance use levels of care can be measured.[13] 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.[14]

In closing, the American Society of Addiction Medicine wants to emphasize its thanks for the opportunity to submit comments. 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

President, American Society of Addiction Medicine

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[13] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. The *ASAM Criteria: Treatment for Addictive, Substance-Related and Co-Occuring Conditions.* 3rd ed. Carson City, NV: The Change Companies; 2013.
[14] 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.