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September 10, 2018

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS-1693-P).

Dear Administrator Verma,

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing more than 6,000 physicians and other clinicians who specialize in the prevention and treatment of addiction, thank you for the opportunity to comment on the notice of proposed rulemaking (NPRM) regarding the *Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program*.

First, we are pleased that the agency is considering the development of a separate payment for the treatment of a substance use disorder (SUD). While it is important to ensure that all individuals with an SUD receive the appropriate treatment, we urge the agency to consider the implications of creating a bundled payment for SUD. Treatment modalities, clinical guidelines, episode duration, as well as many other important factors can differ for SUD depending on the types of drug use involved. ASAM and the American Medical Association (AMA) have worked collaboratively over the past few years to develop the [Patient-Centered Opioid Addiction Treatment \(P-COAT\) alternative payment model \(APM\)](#) which is carefully tailored to address the treatment of addiction involving opioid use. We offer recommendations below about how this model could fit into the agency's priorities.

Second, ASAM is pleased to provide comments on the agency's proposal to modify the documentation requirements and add an additional billing code for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services in response to the opioid overdose epidemic. With respect to

SBIRT, while it can be an important tool used to for identifying, reducing, and preventing the unhealthy use of substances like alcohol and tobacco, we have concerns about the breadth of these proposed changes given the inconclusive evidence of SBIRT's effectiveness for illicit drug use. Additionally, ASAM is delighted that CMS is proposing to modify burdensome evaluation and management (E/M) coding documentation guidelines. Despite the gravity of the opioid overdose crisis, physicians continue to spend a significant amount of time on administrative requirements that could be better spent with patients. With that being said, however, we encourage the agency to engage with ASAM and other national medical and specialty societies regarding concerns over proposed changes to level 2-5 E/M codes. We have provided additional information below about the possible impacts of these proposed efforts to combat the opioid overdose epidemic.

Finally, we are pleased to provide comments below on the agency's proposals for the Quality Payment Program (QPP).

Thank you for the opportunity to comment on the NPRM regarding the 2019 Medicare Physician Fee Schedule, and implementation of year three of QPP. If you have any questions or need further clarification, please do not hesitate to contact Corey Barton, Manager, Private Sector Relations for ASAM at 301-547-4106.

Sincerely,

A handwritten signature in black ink that reads "Kelly J. Clark". The signature is written in a cursive, flowing style.

Kelly J. Clark, MD, MBA, DFAPA, DFASAM
President, American Society of Addiction Medicine

2019 MPFS Detailed Comments
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Payment for SUD Treatment

Background

ASAM firmly believes that addiction is a primary, chronic brain disease for which each individual's treatment plans must emphasize that treatment and recovery from addiction is a life-long process. There should be no episodic or fixed time limits on treatment and recovery. Unfortunately, notwithstanding the current, overwhelming need for treatment of opioid use disorder (OUD), thousands of individuals are not receiving evidence-based treatment for this condition which includes the use of FDA-approved medications in combination with medical and psychosocial supports. Therefore, we strongly urge CMS to focus its payment development efforts on addressing OUD, not SUD in general. For your convenience, we have outlined below why an alternative payment model is critical to addressing the needs of individuals suffering with OUD.

As previously stated, the use of medications in combination with medical and psychosocial supports for the treatment of OUD remains significantly underutilized. There are many factors that have contributed to this underutilization, including the highly fragmented nature of insurance coverage, coverage that is not on par with treatment services for other chronic diseases, high out-of-pocket expenses for patients, and a lack of access to qualified providers. Additionally, the current healthcare financing structure for outpatient addiction treatment services is a significant barrier to treating effectively patients with OUD. Namely:

- Evaluation and Management (E/M) services payments are insufficient to support the time a physician needs to identify and diagnose OUD and develop a treatment plan that the patient is willing to pursue;
- There is a limited payment structures available to enable primary care physicians and addiction specialists other than psychiatrists to communicate by phone or email;
- Payments for services delivered by behavioral health agencies do not require coordination with medical therapies delivered by physician practices;
- Payments for behavioral health services delivered by primary care and addiction specialist practices are generally inadequate to cover costs, and the credentials required for billing are often unnecessarily and unrealistically high;
- Insurers do not consistently pay for technology-based treatment and recovery support tools, remote monitoring and/or services that are used in conjunction with standard outpatient treatment for opioid addiction;
- Many insurers do not pay for transportation, housing, or other non-medical services that patients may need to succeed in addiction treatment;
- Utilization management requirements for medications and intensive outpatient (IOP) services make it difficult to deliver timely, effective treatment to patients; and
- Billing for treatment services is highly complex and continues to evolve with the passage of federal and state legislation.

In addition to problems with the country's existing healthcare financing structure for outpatient addiction treatment for OUD, the siloed nature of addiction treatment in the United States has led to higher total healthcare costs and higher societal costs.

Some drivers of these higher costs include:

- Ineffectively treated patients with OUD making frequent visits to the emergency room due to their addiction and other health problems;
- Increased hospital admissions and length of hospital stays for opioid-related health problems;
- Ineffectively treated patients with OUD are associated with high rates of absenteeism from work and lower productivity at work;
- Ineffectively treated patients with OUD have increased involvement with the criminal justice system and increase related spending; and
- Higher levels of spending on more expensive residential addiction treatment due to a lack of adequately supported outpatient addiction treatment for OUD.

The absence of these systems reinforce the need for alternative payment models that emphasize the importance of care coordination, as well as the appropriate roles of medical, behavioral, and social support providers in the provision of treatment to save lives. However, ASAM has concerns about implementing new payment models for the treatment of OUD into the budget-neutral MPFS. Given the significant investments required to combat and end the opioid overdose epidemic, we do not believe treatment access should be subject to the MPFS which does not account for public health crises, such as the opioid overdose epidemic. Additionally, the MPFS does not account for quality care or provider accountability. As a result, we encourage the agency to provide a separate payment through an APM framework, such as the [P-COAT](#) concept developed by ASAM and the AMA that aims to provide quality care by increasing investment and rewarding good performance while ensuring accountability.

Specifically, ASAM and the AMA have designed the P-COAT model to:

- Provide the appropriate financial support to enable physicians and other clinicians to provide services for individuals with opioid use disorder;
- Encourage more primary care practices to provide treatment;
- Encourage the coordinated delivery of three types of services needed for effective outpatient care of patients with addiction involving opioid use – medical services, psychological and counseling therapies, and social services support;
- Reduce or eliminate spending on outpatient treatments that are ineffective or unnecessarily expensive;
- Reduce use of inpatient/residential addiction treatment for patients who could be treated successfully through office-based or outpatient treatment;
- Improve access to evidence-based outpatient care for patients being discharged from more intensive levels of care;
- Reduce spending on potentially avoidable emergency department visits and hospitalizations related to addiction involving opioid use;
- Increase the proportion of individuals with an addiction involving opioid use who are successfully treated; and
- Ultimately reduce deaths caused by opioid overdose and complications of opioid use.

Payment Structure

To realize these goals, we encourage CMS to adopt a payment structure like the one envisioned by [P-COAT \(outlined in Appendix A and linked here\)](#). Under this payment structure, physician

teams would be eligible to receive two new types of payments for two separate phases of office-based opioid treatment: treatment initiation and maintenance of treatment. These two separate structures recognize the distinct, but related phases of treating OUD.

Under the initiation of treatment payment, physician practices would receive a one-time payment to support the evaluation, diagnosis, and treatment planning for a patient with an OUD, as well as the initial month of outpatient treatment for the patient. This payment would be expected to be adequate to cover the costs of these services and would be significantly higher than monthly payments for ongoing treatment.

Separately, a monthly payment would be provided to physician practices to provide or coordinate the provision of ongoing outpatient medical services, psychological treatment, and social services for patients who have successfully initiated treatment for an OUD. Monthly payments would continue if the patient was determined to be appropriate for continued treatment.

We appreciate that CMS has involved stakeholders in determining how to value this proposed new payment. We outline our approach to this on pages 11-15 of Appendix A. Essentially, we believe that the best approach to valuing any new payment would be to provide physicians and other qualified practitioners with payments that would reflect: (1) the difference in complexity associated with patients in ASAM Levels of Care 1 and 2 within the different care delivery options; (2) the ability of addiction specialists to provide advanced care; (3) and the additional financial support necessary to coordinate treatment services in outpatient settings structured to deliver the complete suite of medical, psychological, and social support services. ASAM welcomes engagement with CMS on further defining and valuing a new APM for OUD.

Quality Care

ASAM also believes that the addition of a new payment for outpatient OUD treatment would be extremely beneficial in providing the financial resources necessary to increase access to quality care. Under P-COAT, physician's billing for this new payment would be accountable for quality and outcomes of the care delivered to patients. On page 16 of Appendix A, we outline the quality standards that physicians and other practitioners should attest they have met, or will meet, before they bill for payments. Consistent with CMS' Patients Over Paperwork initiative, attestation would hold health care providers accountable while still ensuring that they are spending their valuable time with patients. Under this proposal, CMS would preserve the ability to perform audits/reviews at any time. Subsequent failure to meet any of the quality standards for a patient would mean that the healthcare provider could not bill for that patient. We encourage CMS to condition any new payment arrangement on the quality standards listed on page 16 of Appendix A.

Performance and Accountability

At the same time, it is important to reward providers for good performance. As an example, payments to providers participating in P-COAT would be adjusted based on their performance on spending and outcome measures. The physician practice's performance on each measure would be compared to the average performance on that measure of all practices receiving the payment during the prior year for the same category of patients. All participating practices would receive a default payment amount for meeting quality standards. However, practices would be eligible for payment adjustments following the performance year (positive or negative) based on their performance on a set of performance measures. We encourage CMS to incorporate

performance and accountability metrics into a new payment for the treatment of OUD using this APM framework.

Treatment and Care Delivery Options

In each phase, patients with OUD would be expected to receive three types of outpatient services:

- Office-based outpatient medical treatment using either buprenorphine or naltrexone;
- Appropriate outpatient psychological and/or counseling therapy services;
- Appropriate coordination of services such as care management, social support, and other necessary medical services to treat the patient's condition.

P-COAT is only designed to support office-based opioid treatment (OBOT) using buprenorphine or naltrexone, and to be consistent with the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider for ASAM Level 1 or Level 2 outpatient services. Since the use of methadone to treat OUD is generally not available in OBOTs, opioid treatment programs (OTPs) using methadone, and partial hospitalization and inpatient/residential addiction treatment for patients who need those more intensive levels of services, would continue to be paid for under current payment mechanisms or under APMs specifically designed for those types of treatment.

Some physician practices and provider organizations would be able to deliver all three outpatient services. However, many physician practices would only be able to provide medical treatment and care management services, and they would need to collaborate with addiction specialists or behavioral health organizations when available and feasible to ensure a patient can receive the full range of medical, psychological, and social support services in a coordinated manner. A physician practice could only receive P-COAT payments if it was part of an organized treatment team that could deliver, or contract to deliver, all three of these services.

Eligible Practitioners

It is critical that that new payment structures solve the current problems with our payment and delivery system without creating new problems in the process. The only way to ensure that new payment models are structured properly is to involve physicians with direct experience and demonstrated success in treating individuals with addiction. Treating OUD requires a wide array of practitioners to deliver the necessary medical, behavioral, and social support services needed to enable successful treatment and life-long recovery. We encourage CMS to design a payment framework that encourages the participation of providers qualified to deliver these services. Particularly, treatment teams should include physicians, physician assistants, or nurse practitioners who possesses a Drug Addiction Treatment Act (DATA) 2000 federal waiver to prescribe buprenorphine for the treatment of OUD. These providers could bill for payments to support the beginning and continuity of medical services necessary for OUD treatment using buprenorphine or naltrexone.

Additionally, treatment teams should include one or more physicians, psychologists, counselors, nurses, social workers, or other qualified healthcare professionals, who are licensed and certified to provide appropriate psychiatric, psychological, or counseling services to individuals with an OUD. These practitioners should have contracts or collaboration agreements with the practitioner prescribing buprenorphine or naltrexone to deliver services to patients in a coordinated way. We urge CMS to also ensure that treatment teams include one or more nurses,

social workers, pharmacists, or other healthcare or social services professionals, who have the training and skills necessary to help individuals with an OUD address non-medical needs. To ensure care coordination, these members of the treatment team should also have a contract or collaboration agreement with the practitioner prescribing buprenorphine or naltrexone.

Where available, treatment teams should also include physicians who specialize in addiction medicine. These specialists would be available to treatment teams for consultative support, including telephonic/electronic support to the waived practitioner via telephonic or electronic communication links. Addiction specialists would also be available to assist with the treatment needs of more complex patients, such as those requiring intensive outpatient services. Addiction specialists should be certified in addiction medicine, as evidenced by board certifications in addiction medicine from the American Board of Addiction Medicine (ABAM), the American Board of Preventive Medicine (ABPM), the American Osteopathic Association (AOA), ASAM, or be board certified in addiction psychiatry by the American Board of Psychiatry and Neurology (ABPN). Together, these treatment teams would be equipped to provide the full range of medical, psychological, and social support services. Again, we encourage CMS to adopt these proposals under APMs that account for value, quality, and performance.

Screening, Brief Intervention, and Referral to Treatment Proposals

Beginning with the 2019 Medicare Physician Fee Schedule, CMS proposes the elimination of the SBIRT service-specific documentation requirements to increase the utilization of these services. The agency also proposes creating a third SBIRT HCPCS code, G5BR1 (5-14 minutes) for use by practitioners who may not currently be able to meet the 15-minute threshold for billing for SBIRT. While SBIRT services are very important tools used to identify, reduce, and prevent the unhealthy use of certain substances, we have concerns about the agency's intention to remove these documentation guidelines for the purposes of responding to the opioid overdose crisis. According to a white paper from SAMHSA, "there is substantial research on the effectiveness of SBIRT in reducing risky alcohol consumption. However, the evidence for the effectiveness of SBIRT in reducing risky drug use, although promising, is still accumulating."¹

Additionally, while the US Preventive Services Task Force (USPSTF) has recommended that "clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse,"² the task force has separately concluded that the "current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use."³ Conclusively, the USPSTF has concluded that practitioners should offer or provide SBIRT for alcohol misuse, while stating the evidence is insufficient to recommend that practitioners offer SBIRT for illicit drug use. Therefore, ASAM disagrees that practitioners are not utilizing SBIRT for illicit drug use due to service documentation requirements. Rather, we find that it's likely due to the absence of conclusive evidence.

Therefore, ASAM supports removing the service documentation requirements for SBIRT when used to screen for unhealthy alcohol use, but not when used to screen for illicit drug use. Additionally, we encourage CMS to finalize guidance that allows the newly proposed SBIRT HCPCS code to be used for alcohol, but not illicit drug use. While ASAM supports prevention strategies that will help turn the tide of the opioid overdose crisis, significant evidence does not yet exist to suggest that SBIRT for illicit drug use is one of those effective strategies.

Evaluation and Management Documentation Guidelines and Payment Changes

We greatly appreciate the efforts CMS has taken to increase the amount of time physicians spend with their patients by reducing the administrative burden of E/M coding documentation requirements. We agree that physicians should spend more time with their patients than on paperwork. However, we are concerned with the agency's proposal to collapse levels 2-5 E/M new and established patient codes into one payment level. Finalizing this proposal would have dangerous consequences for addiction medicine physicians and their patients. Specifically, addiction medicine physicians and other practitioners treating addiction often bill level 4 and 5 E/M codes due to the complex nature of the patient populations they treat. These patients usually have comorbidities, as well as psychosocial needs that very often influence the time a physician must devote to treatment.

According to our analysis, the agency's plan to collapse level 2-5 E/M codes would reduce payment for level 5 new and established patient office visits by as much as 37%. These cuts have the potential to drastically impact the ability of physicians to provide care for Medicare beneficiaries, which have seen sharp increases in hospitalizations due to opioid poisonings since 1999.⁴ Additionally, this proposal would limit the ability of physician practices to hire and retain qualified staff to provide the full range of biopsychosocial services needed to care for patients with an OUD. As noted in a separate comment letter by the AMA and the The Patient-Centered Evaluation and Management Services Coalition, and signed by multiple state and national specialty medical organizations, we urge CMS to maintain the existing, five level coding structure, and move to adopt proposals to:

- Allow physicians to document visits based solely on the level of medical decision-making or the face-to-face time of the visit as an alternative to the current guidelines;
- Change the required documentation of the patient's history to focus only on the interval history since the previous visit;
- Eliminate the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient; and
- Remove the need to justify providing a home visit instead of an office visit.

However, ASAM implores CMS to postpone finalizing the E/M payment proposals, as well as outpatient visit coding, until a consensus about an equitable coding structure emerges. We ask that the agency work with ASAM and the rest of the medical community to reach this consensus. We are confident that the agency agrees that it is critically important to facilitate access to addiction treatment through the Medicare program at a time when deaths from opioid poisonings continue to rise.

Quality Payment Program

As part of the agency's response to the opioid overdose crisis, CMS has proposed changing the definition of a high priority measure to include quality measures that relate to opioids. Hence, CMS is proposing to define a high priority measure as an outcome, appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure. This change would give practitioners treating patients with an OUD an additional high priority measure to choose from and would provide an additional pathway to earn bonus points that bring practitioners closer to a neutral or positive payment adjustment. While we appreciate CMS is proposing this definition change to help address the opioid overdose crisis, we encourage CMS to also focus their efforts on the development of outcome measures that evaluate the improvement of patients' conditions following the initiation of evidence-based treatment for

addiction, such as medications in combination with psychosocial supports to treat addiction involving opioid use.

Additionally, CMS seeks comment on what aspects should be measured considering this proposed definition expansion. Considering the request, the patient population to be measured, the providers who are affected by measurement implementation, and the narrow area of impact, ASAM recommends that future high-priority, opioid-related measurements should be focused on patient education, as well as measures that evaluate use of evidence-based treatment of addiction involving opioid use. More specifically, patient education should center on prevention, and outcomes that can be more effectively measured by assigning patients to one of three possible target cohorts:

- Patients that are currently taking prescription pain medications;
- Patients that are being treated with prescription pain medications; and
- Patients that are not currently taking prescription pain medications.

We strongly urge CMS to consider the beneficial impacts of adding these two new focus areas to the agency's ongoing work to identify the components of opioid-related measures.

Addition of Continuity of Pharmacotherapy Measure

In this proposed rule, CMS is proposing to adopt ten new quality measures into the MIPS program for the 2021 payment year and beyond. Included in this list is the "Continuity of Pharmacotherapy for Opioid Use Disorder" proposed quality measure stewarded by the University of Southern California. Using a six-month marker as a surrogate for long term care retention, this measure evaluates retention in treatment using pharmacotherapy for OUD. Retention in opioid agonist treatment has historically produced better outcomes for patients. While long-term use of pharmacotherapy is the evidence-based treatment for addiction involving opioid use, it has not always been used as the treatment standard. We are pleased that CMS is reinforcing this best practice with the addition of this quality measure. We agree with CMS that the adoption of this measure will fulfill a clinical concept currently not represented in the MIPS program.

However, ASAM has some concerns about the potential for confounders in this measure's data sources, given that it uses medication doses to measure treatment. For example, if the doses were not observed, there is a possibility the medication was diverted (except for injected doses) or not taken (oral naltrexone). If pharmacy claims are used, the data would neglect the use of methadone which is dispensed in OTPs. Should practitioners use prescription drug monitoring program (PDMP) data, the use of naltrexone could also be omitted given that these databases usually do not track naltrexone, which is not a controlled substance. If the Treatment Episode Data Set (TEDS) is used, it overlooks treatment delivered in office-based, hospital, and criminal justice settings. TEDS may also neglect travel courtesy doses and may penalize practitioners for transfers to other clinics or to primary care, despite any potential for increased outcomes.

Additional potential confounders might include a change in medications, where for example, an extended-release naltrexone injection could follow the use of buprenorphine in withdrawal management; extended-release buprenorphine and naltrexone injections are preceded by inductions using oral formulations first; or where practitioners switch patients from buprenorphine to methadone, or vice versa. While ASAM supports the adoption of this measure,

we strongly urge CMS to consider, and account for accordingly, the possibilities of confounders as the agency determines whether and how to adopt this measure.

Interoperability Measures

CMS has proposed adopting two new opioid-related interoperability measures. Namely, the agency is seeking to add the “Query of the Prescription Drug Monitoring Program (PDMP)” and the “Verify Opioid Treatment” measures to the list of available measures. ASAM supports the adoption of these new measures, but we strongly caution CMS to work with EHR vendors to ensure that these new measures are properly and promptly integrated into existing platforms given the gravity of the opioid overdose crisis. Additionally, we encourage CMS to account for the different state laws that govern each individual state-level PDMP program. Should CMS adopt the PDMP measure, we urge the agency to consider the recommendations provided in ASAM’s [Public Policy Statement on Prescription Drug Monitoring Programs \(PDMPs\)](#).⁵

Additional Regulatory and Sub-Regulatory Changes

We appreciate the agency’s request for additional regulatory and sub-regulatory changes that might be valuable in combatting the opioid overdose epidemic in the Medicare program. There are several areas ASAM encourages CMS to consider as officials finalize this rule. First, we encourage the agency to consider the major treatment gaps when patients voluntarily or involuntarily move from commercial, employer-based, and Medicaid health plans to Medicare.

For example:

- Medicare health plan formularies often do not cover the pharmacotherapies that patients were taking under their previous health plan;
- Medicare plans may require a prior authorization for medications, although it was not required by their previous plan;
- OTPs, which have historically been a major source of addiction treatment and services are not covered by Medicare; and
- Some practitioner types, including some behavioral health practitioners are not covered by Medicare.

Additionally, the agency should consider:

- Creating a seventh protected class of Part D drugs for all FDA-approved medications for the treatment of addiction involving opioid use;
- Implementing prescription drug coverage for short-term supplies of acute pain medications to help combat the inappropriate prescribing of prescription opioid medications for pain;
- Supporting innovation for PDMP enhancement technologies and study best practices for integrating PDMPs into EHRs and data presentation in a meaningful, user-friendly manner that enhances physician workflow;
- Encouraging healthcare providers to know how to engage a patient whose PDMP report indicates he or she may be inappropriately accessing controlled substances. CMS should also support an incentive and accountability program that motivates providers to use PDMP’s and engages patients when appropriate;

- Only paying for appropriate and medically-necessary drug testing that relies on use of [The ASAM Consensus Document on Appropriate Use of Drug Testing in Clinical Addiction Medicine](#),⁶ or other widely used, evidence-based consensus document; and
- Paying only for evidence-based care that relies on use of the ASAM Criteria or other comparable evidence-based patient placement assessment tools and nationally-recognized and research-validated program standards.

¹ SAMHSA (2011). Screening, Brief Intervention and Referral to Treatment (SBIRT) in Behavioral Healthcare [White paper]. Retrieved August 24, 2018, from SAMHSA: https://www.samhsa.gov/sites/default/files/sbirtwhitepaper_0.pdf

² US Preventive Services Task Force. (2015). Final update summary: Alcohol misuse: Screening and behavioral counseling interventions in primary care. US Preventive Services Task Force. <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care>

³ US Preventive Services Task Force. "Final update summary: Drug use, illicit: Screening." US Preventive Services Task Force (2015). <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/drug-use-illicit-screening>

⁴ Tedesco, D., Asch, S. M., Curtin, C., Hah, J., McDonald, K. M., Fantini, M. P., & Hernandez-Boussard, T. (2017). Opioid abuse and poisoning: trends in inpatient and emergency department discharges. *Health Affairs*, 36(10), 1748-1753.

⁵ American Society of Addiction Medicine. Public Policy Statement on Prescription Drug Monitoring Programs (PDMPs). Rockville, MD: American Society of Addiction Medicine; 2018. [https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2018/04/24/prescription-drug-monitoring-programs-\(pdmps\)](https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2018/04/24/prescription-drug-monitoring-programs-(pdmps)).

⁶ Jarvis, M., Williams, J., Hurford, M., Lindsay, D., Lincoln, P., Giles, L., ... & Safarian, T. (2017). Appropriate use of drug testing in clinical addiction medicine. *Journal of addiction medicine*, 11(3), 163-173.

APPENDIX A

PATIENT-CENTERED OPIOID ADDICTION TREATMENT (P-COAT)

Alternative Payment Model (APM)



ASAM American Society of
Addiction Medicine



An Alternative Payment Model Concept for Office-based Treatment of Opioid Use Disorder

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I. Need for an Alternative Payment Model for Opioid Use Disorder and Addiction

A. Improving Services to Patients with Opioid Use Disorder

Since 1999, there has been a growing epidemic across the United States of deaths due to opioid overdoses.^{1,2} This epidemic is widespread, growing rapidly, and has overtaken many other leading causes of death.³ Substantial medical literature documents the clinical effectiveness of medication-assisted treatment (MAT)⁴ for opioid addiction. Despite this evidence and the worsening epidemic, MAT is significantly underutilized due to many factors, including lack of accessibility.⁵ Of the estimated 2.5 million patients who need specialty treatment for opioid use disorder (OUD), only a small fraction of the population is able to access it.⁶ According to a recent report by the Blue Cross Blue Shield Association (BCBSA), the number of BCBS members with an opioid use disorder diagnosis surged 493 percent, while the number of BCBS individuals using MAT to treat their diagnoses only rose by 65 percent.⁷ This means the rate of diagnoses grew nearly eight times as quickly as the rate of MAT use.

Federal law requires practitioners⁸ to have specific education in order to be certified to prescribe buprenorphine to their patients as part of comprehensive MAT for OUD that also includes behavioral therapy and other supportive services.⁹ As of January 2018, data from the Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that over 45,000 physicians have been certified to provide these services.¹⁰ Although the number of certified physicians has significantly increased in recent years, 72% of certified physicians are limited to treating 30 patients, with the remainder certified for treating up to 100 or 275 patients, and it is estimated that about 40% of physicians who become certified do not write any prescriptions for buprenorphine.¹¹

Many factors contribute to the underutilization of MAT. One major hurdle has been the poor integration of MAT as a pharmacy benefit into a historically complicated and highly fragmented insurance coverage and payment structure for behavioral health benefits. Even within an already complicated system, many insurance plans have not provided sufficient coverage for services related to substance use disorder (SUD). When coverage is provided, it is often handled differently than treatment for other kinds of diseases and conditions, and often through a separate insurance plan altogether.¹² Coverage is more limited and requires higher out-of-pocket spending by patients.¹³ There are also few Drug Addiction Treatment Act of 2000 (DATA 2000)¹⁴-waivered practitioners and physicians trained in the specialty of Addiction Medicine, making it difficult for patients to find specialty providers. For those practitioners that become certified to provide MAT, many feel that they that they can't appropriately manage patients with an OUD without having access to specialists in addiction medicine.

A growing number of payers have recognized the problems clinicians and patients face and they have begun to reach out to clinicians to develop solutions beyond what has been mandated by state laws. The payers are at various stages in their development of programming currently. Some payers have opened their behavioral health networks to medical providers who are certified in Addiction Medicine to increase member access to MAT services. A few commercial insurers have included opioid treatment programs (OTPs) in their networks. Some prior authorization requirements for MAT have been curtailed or eliminated altogether by commercial payers or by state law.¹⁵ One large national payer has joined forces with larger regional and local

substance use providers to use alternative payment models (APMs) to encourage members to remain in local treatment in their communities. A few states have implemented state-wide expansion of substance use disorder benefits including MAT in the Medicaid population with some progressive hub-and-spoke models demonstrating success.¹⁶ CMS is evaluating possible improvements to Medicare payment for substance use disorder treatment including both changes to the physician fee schedule and APMs.

The goal of the American Society of Addiction Medicine (ASAM) is to build on these endeavors by creating an APM that can be feasibly implemented by payers and a wide range of providers to achieve improved outcomes for patients with opioid use disorder.

B. Problems with Current Payment Systems¹⁷

Current healthcare payment systems have several problems that create barriers to the successful treatment of patients with an OUD. These include:

- Evaluation & Management (E/M) services payments are insufficient to support the time a physician or a qualified healthcare professional (QHP) takes to identify and diagnose an OUD and to develop a treatment plan¹⁸ that the patient is willing to pursue;¹⁹
- E/M services payments require face-to-face visits with patients and there is limited support for telephone, email, or other electronic communications with patients;
- There is a limited payment structure available to enable primary care physicians/clinicians and addiction specialists other than psychiatrists to communicate by phone or email to help the primary care practitioners (PCPs) to diagnose and develop effective treatment plans for opioid use disorder;
- Payments for services delivered by behavioral health services agencies do not require coordination with medical therapies delivered by physician practices;
- Payments for behavioral health services delivered by primary care and addiction specialist practices are generally inadequate to cover costs, and the credentials required for billing are often unnecessarily and unrealistically high;
- Insurers do not yet pay for technology-based treatment and recovery support tools, remote monitoring and/or services that are used in conjunction with standard outpatient treatment for opioid addiction;
- Most insurers do not pay for transportation, housing, or other non-medical services that patients may need to succeed in addiction treatment;
- Prior authorization requirements for medications and intensive outpatient (IOP) services make it difficult to deliver timely, effective treatment to patients; and
- Billing for substance use disorder services is highly complex and continues to evolve with passage of federal and state legislation.

These barriers lead to higher total healthcare costs and higher costs to society, because:

- patients who are not treated effectively make frequent visits to the Emergency Department and are hospitalized frequently due to their addiction and other health problems;
- patients who are not treated effectively have longer hospital stays and are more likely to be readmitted to the hospital after discharge;

- patients who are not treated effectively have high rates of absenteeism from work and have lower productivity when they are at work;
- patients who are not treated effectively are more likely to be involved in crimes, resulting in increased spending in the criminal justice system; and
- lack of adequate support for office-based treatment leads to higher spending on IOP treatment and on inpatient/residential programs.

II. Overview of Patient-Centered Opioid Addiction Treatment Payment

A. Goals for an Alternative Payment Model

The Patient-Centered Opioid Addiction Treatment Payment (P-COAT) is an Alternative Payment Model designed to improve outcomes and reduce spending for opioid addiction by overcoming the barriers in the current payment system for successful outpatient care.

Specific goals of P-COAT are:

- to provide appropriate financial support to enable physicians and other clinicians to provide successful MAT services for individuals with opioid use disorders;
- to encourage more primary care practices to provide MAT;
- to encourage coordinated delivery of three types of services needed for effective outpatient care of patients with opioid addiction – medication therapy, psychological and counseling therapies, and social services support;
- to reduce or eliminate spending on outpatient treatments that are ineffective or unnecessarily expensive;
- to reduce use of inpatient/residential addiction treatment for patients who could be treated successfully through office-based or outpatient treatment;
- to improve access to evidence-based outpatient care for patients being discharged from more intensive levels of care;
- to reduce spending on potentially avoidable emergency department visits and hospitalizations related to opioid addiction;
- to increase the proportion of individuals with an opioid addiction who are successfully treated; and
- to reduce deaths caused by opioid overdose and complications of opioid use.

B. Structure of the Alternative Payment Model

1. Separate Payments Supporting Two Phases of Care

Under the Patient-Centered Opioid Addiction Treatment Payment (P-COAT), practices that are part of Opioid Addiction Treatment Teams (OATTs) would be eligible to receive two new types of payments for two separate phases of office-based opioid treatment:

1. **Initiation of Medication-Assisted Treatment (IMAT).** This would be a one-time payment to support evaluation, diagnosis, and treatment planning for a patient with an opioid use disorder and the initial month of outpatient medication-assisted treatment for the patient. This payment would be adequate to cover the costs of these services and would be significantly higher than monthly payments for ongoing treatment (MMAT).
2. **Maintenance of Medication-Assisted Treatment (MMAT).** This would be a monthly payment to provide or coordinate the provision of ongoing outpatient medication, psychological treatment, and social services to a patient who has successfully initiated treatment for an OUD. Monthly payments could continue if the patient was determined

to be appropriate for continued therapy. This payment would be adequate to cover the costs of these services.

2. Payments Designed to Support High Quality Care

In each of the two phases, higher amounts would be paid for patients with more complex needs that require more intensive supervision and services consistent with consistent with the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider. In addition, physician practices and OATTs would need to meet minimum standards of quality to receive the payments, and the amounts of payments would be adjusted based on performance on quality, spending, and outcome measures.

3. Add-On Payments to Support Integration of Technology-based Treatment and Recovery Support Tools

Within each phase of care, add-on payments would be available for practitioners that use treatment and recovery support tools.²⁰ There is sufficient evidence to support the effectiveness of these tools for specific uses with some types of patients, including—

- Remote patient monitoring for patients with chronic conditions;
- Communication and counseling for patients with chronic conditions;
- Psychotherapy as part of behavioral health.²¹

Allowing for, and reimbursing technology-based treatment and recovery support tools can be a great way to expand access to treatment in areas where there is a lack of behavioral health/trained addiction treatment providers, as well as create an incremental improvement and support for DATA 2000 providers who may be reluctant to prescribe MAT due to lack of additional support services in their area.

There has been a well-documented rapid rate of technological innovation and broad adoption by consumers and patients as well as health care providers of new technologies that can be leveraged and modified to power health care services.²² Utilizing these new modalities to provide care that is the same as in-person care and education, or to offer new clinical services altogether promises to improve access to care and help fill the gaps in care as the demand for quality addiction treatment providers and services far outweighs the supply.

Incentivizing recovery support tools will assist physician practices, health systems, and other health care providers in adopting new technologies that will help diagnose and treat earlier manifestations of addiction in less costly care settings and help patients improve compliance and adherence with their care plans, while decreasing risk of relapse.

4. Payments Supporting Different Ways of Delivering Comprehensive Services

In each phase, patients would be expected to receive three types of outpatient services:

1. Office-based outpatient medical treatment using either buprenorphine or naltrexone;
2. Appropriate outpatient psychological and/or counseling therapy services;
3. Appropriate coordination of services such as care management, social support, and other necessary medical services to treat the patient's condition.

P-COAT is only designed to support office-based opioid treatment (OBOT) using buprenorphine or naltrexone consistent with the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider for Level 1 or Level 2 outpatient services. Given that the use of methadone to treat addiction is not available in OBOTs and is only allowed in OTPs²³, OTPs using methadone, and partial hospitalization and inpatient/residential addiction treatment for patients who need those more intensive levels of services, would continue to be paid for under current payment mechanisms or under alternative payment models specifically designed for those types of treatment.

Some physician practices and provider organizations would be able to deliver all three outpatient services. However, many physician practices would only be able to provide medical treatment and care management services, and they would need to collaborate with addiction specialists or behavioral health organizations when available and feasible to ensure a patient can receive the full range of medical, psychological, and social support services in a coordinated manner. A physician practice could only receive P-COAT payments if it was part of an organized Opioid Addiction Treatment Team (OATT) that could deliver or contract to deliver all three of the services listed above.

Some providers may be able to perform drug testing and/or dispense medications through their practice setting. Although this model does not specifically account for those services, they are often best practice when managing patients with OUD because of the increased coordination of care and oversight provided by these mechanisms. Payers should consider including those services in the APM when appropriate and available.

To support different organizational mechanisms for delivering the services, P-COAT payments in each of the phases could be paid in three different ways:

Option A: Payments for Medical Management by a DATA 2000 Practitioner

Under Option A, the Opioid Addiction Team would consist of:

- A physician, or other qualified healthcare professional with a waiver²⁴ to prescribe buprenorphine under the Drug Addiction Treatment Act of 2000. This practitioner could bill for IMAT/MMAT payments to support medication-assisted treatment (using buprenorphine or naltrexone) and care management services for the patient.
- A physician who specializes in addiction medicine who would be available for consultative support, including telephonic/electronic support to the waived practitioner via telephonic or electronic communication links. This Addiction Specialist could bill for payments to support consultations with the DATA 2000 practitioner. An Addiction Specialist would need to be board certified in addiction medicine by the American Board of Addiction Medicine (ABAM), the American Board of Preventive Medicine (ABPM), American Osteopathic Association (AOA), or ASAM or be board certified in addiction psychiatry by the American Board of Psychiatry and Neurology.
- One or more physicians, psychologists, counselors, nurses, social workers, or other qualified healthcare professionals, who are licensed and certified to provide appropriate psychiatric, psychological, or counseling services to individuals with an opioid use disorder, and who have contracts or collaboration agreements with the practitioner prescribing buprenorphine or naltrexone to deliver services to patients in a coordinated

way. Under Option A, these providers would be paid using existing billing codes or other payment methods that support their services.

- One or more nurses, social workers, pharmacists, or other healthcare or social services professionals, who have the training and skills necessary to help individuals with an opioid use disorder to address non-medical needs, and who have a contract or collaboration agreement with the practitioner prescribing buprenorphine or naltrexone to deliver services to patients in a coordinated way. Under Option A, these providers would be paid using existing billing codes or other payment methods that support their services.

Option B: Payments for Medical Management by an Addiction Specialist

Under Option B, the Opioid Addiction Team would consist of:

- A physician who specializes in addiction medicine. This Addiction Specialist could bill for IMAT/MMAT payments to support medication-assisted treatment and care management services for the patient. An Addiction Specialist would need to be board certified in addiction medicine by the American Board of Addiction Medicine (ABAM), the American Board of Preventive Medicine (ABPM), American Osteopathic Association (AOA), or ASAM or be board certified in addiction psychiatry by the American Board of Psychiatry and Neurology.
- One or more physicians, psychologists, counselors, nurses, social workers, or other qualified healthcare professionals, who are licensed and certified to provide appropriate psychiatric, psychological, or counseling services to individuals with an opioid use disorder, and who have contracts or collaboration agreements with the Addiction Specialist to deliver services to patients in a coordinated way. Under Option B, these providers would be paid using existing billing codes or other payment methods.
- One or more nurses, social workers, pharmacists, or other healthcare or social services professionals, who have the training and skills necessary to help individuals with an opioid use disorder to address non-medical needs, and who have contracts or collaboration agreements with the Addiction Specialist to deliver services to patients in a coordinated way. Under Option B, these providers would be paid using existing billing codes or other payment methods that support their services.

Option C: Payments for Comprehensive Services from an Opioid Addiction Team

Under Option C, a single organization would serve as the Opioid Addiction Team, and it would employ or contract with the necessary personnel to prescribe medications, deliver psychiatric, psychological, or counseling services, address non-medical needs, and provide care management services for individuals with an opioid use disorder. This organization would receive “bundled payments” (Comprehensive IMAT/MMAT Payments) designed to cover all those services, and it would not bill for those services using current billing codes.

III. Details of Payments for Each Phase of Treatment

1. Initiation of Medication-Assisted Treatment (IMAT)

1.1. Eligible Patients

A physician practice that is part of an Opioid Addiction Treatment Team could receive an Initiation of Medication-Assisted Treatment (IMAT) Payment for a patient who:

- is diagnosed by a physician as having an opioid use disorder;
- is determined by the physician practice to be appropriate for office-based medication-assisted treatment according to the ASAM Criteria, or other such evidence-based, widely used criteria, and
- agrees to initiate medication-assisted treatment and receive the other services recommended in a Treatment Plan under the supervision of the physician practice.

For patients who needed a partial hospitalization or inpatient/residential treatment, or for patients with more complex needs, payment would be made using current payment systems for those forms of treatment or a different alternative payment model. If the physician believed inpatient treatment was the best option but the patient refused, then the physician would need to define a Treatment Plan with appropriate office-based outpatient treatment that the patient agreed to accept to receive the IMAT payment. In order for the physician practice to receive an IMAT Payment for a patient, and in order for the patient to benefit from the enhanced services available through the payment, the patient would need to explicitly agree to receive all of their addiction-related services from the members of the Opioid Addiction Treatment Team that the physician practice was a part of, or from other providers designated by the Team, for a period of at least one month.

Before agreeing to serve as a patient's Opioid Addiction Treatment Team, the physician could ask the patient to commit to follow the Treatment Plan and take other specific types of actions designed to maximize the Team's ability to deliver care that achieves the best possible outcomes at the most affordable cost.

If a patient begins treatment with the Opioid Addiction Team but does not continue treatment, a physician practice that is part of the same Team could not receive another IMAT Payment for that patient unless six months had elapsed from the previous payment. If the patient disengages in, but then returns to treatment during a six-month period, the practice would receive an IMAT payment to care for that patient. If the patient does not pursue treatment with the Team or stops receiving treatment and then seeks care from a different Team (with different practitioner) that develops a new Treatment Plan, the new Team would be eligible to receive an IMAT payment.

This model does not exclude participation by special populations, including pregnant women. However, providers may choose to exclude from this model those patients who have more complex needs or may need a different level of service not provided by this model. Providers may work with insurers to ensure that this model works for special populations or may decide to use existing payment methods or other APMs to cover these patients.

1.2. Structure of Payments and Services Covered

There would be three different options for IMAT Payments to support different service delivery structures:

Option A: MM-IMAT Payments for Medical Management by a DATA 2000 Practitioner

This option would be used for a practitioner who:

- is not an Addiction Specialist Physician;
- has received a prescribing waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000);
- is prescribing and supervising the patient's medication therapy;
- has a collaborative agreement with an Addiction Specialist Physician to provide consultative support, including telephonic/electronic support if DATA 2000 provider sees patients who qualify for IOP care;
- has a collaborative agreement with other providers or organizations to deliver psychological/counseling and social services support; and
- is coordinating all the addiction-related services the patient is receiving and coordinates those services with any non-addiction related services the patient is receiving.

As shown in Table 1, the DATA 2000 practitioner could bill for and receive a one-time Medical Management for Initiation of Medication-Assisted Treatment (MM-IMAT) payment for delivering ASAM Level 1 office-based medication therapy and care coordination, using billing code xxx11. The DATA 2000 practitioner could still bill for and receive standard Evaluation & Management Services (E/M) payments for face-to-face visits with the patient in addition to the MM-IMAT payment, but the practitioner would not bill for other non-face-to-face care management or collaborative care services during the month in which the MM-IMAT payment was made.

In general, a DATA 2000 practitioner would not deliver medication therapy for patients requiring ASAM Level 2 IOP services, but would refer such patients to an Addiction Specialist who would be paid for those services under Option B. However, if an Addiction Specialist is not available to treat the patient but is available for consultation with the DATA 2000 physician, the DATA 2000 physician could bill for and be paid a higher amount for those patients using billing code xxx12.

The Addiction Specialist Physician could bill for and receive a separate Addiction Specialist IMAT Consultation payment (billing code xxx13) if a consultation was provided to the DATA 2000 practitioner to assist with diagnosis, treatment planning, and initiation of treatment. Only one Consultation payment could be paid during the month in which treatment was being initiated.

TABLE 1
OPTION A: Medical Management Payment for Initiation of Medication-Assisted Treatment (MM-IMAT) by a DATA 2000 Practitioner

Category	Billing Code	Patient Characteristics
Initiation of Level 1 Outpatient Medical Management by a DATA 2000 Practitioner	xxx11	Medical management services provided by a DATA 2000 practitioner with support from an addiction specialist for a patient who meets the standard for outpatient services according to the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider.
Initiation of Level 2 IOP Medical Management by a DATA 2000 Practitioner	xxx12	Medical management services provided by a DATA 2000 practitioner for a patient who meets the standard for IOP services according to the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider if an addiction specialist is not available to directly treat the patient.
Consultation by Addiction Specialist During Initiation of Outpatient Medical Management	xxx13	Support by an addiction specialist physician for a DATA 2000 practitioner providing medical management services for IMAT

The MM-IMAT payments would be designed to provide sufficient additional resources to the DATA 2000 practitioner and the Addiction Specialist to support successful:

- initiation of buprenorphine or naltrexone treatment; and
- care management services for the patient and coordination of addiction services with other services the patient is receiving for other conditions from other physicians and providers.

Payments for psychotherapy, counseling, and social services related to initiation of treatment would be made separately under current payment systems or under alternative payment models specifically designed to more effectively support those services if they were part of the Treatment Plan developed by the physician and delivered by members of the OATT.

Other services related to addiction –, emergency department visits, hospitalizations, etc. – that are received by the patient during the month in which the IMAT payment is billed would also be paid for separately from the IMAT payment. Service such as laboratory testing or medication dispensing are not a part of the model described in this model but may be a part of a reasonable and appropriate part of a payment structure negotiated by payers and providers. If a patient required intensive (inpatient) withdrawal management before they could initiate MAT, those withdrawal management services would be paid for using current payment methods or a different alternative payment model. Payments for treatment of conditions other than addiction, including medical or psychiatric complications of substance use, would continue to be made in addition to the IMAT payments.

Option B: MM-IMAT Payments for Medical Management by an Addiction Specialist

This option would be used for a physician who is an Addiction Specialist and is prescribing and supervising the patient’s medication therapy. The Addiction Specialist could still bill for and receive standard Evaluation & Management Services (E/M) payments for face-to-face visits with the patient in addition to the MM-IMAT payment, but the Addiction Specialist would not bill for other non-face-to-face care management or collaborative care services during the month in which the MM-IMAT payment was made.

As shown in Table 2, the Addiction Specialist Physician could bill for and receive a Level 1 Addiction Specialist IMAT payment (billing code xxx14) for patients requiring ASAM Level 1 Outpatient Services or a Level 2 Addiction Specialist IMAT payment (billing code xxx15) for patients requiring ASAM Level 2 services. These payments would be greater than or equal to the sum of the DATA 2000 IMAT and Addiction Specialist IMAT Consultation payments.

**TABLE 2
OPTION B: Medical Management Payment for Initiation of
Medication-Assisted Treatment (MM-IMAT) by an Addiction Specialist**

Category	Billing Code	Patient Characteristics
Initiation of Level 1 Outpatient Medical Management by an Addiction Specialist	xxx14	Medical management services provided by an Addiction Specialist for a patient who meets the standard for outpatient services according to the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider
Initiation of Level 2 IOP Medical Management by an Addiction Specialist	xxx15	Medical management services provided by an Addiction Specialist for a patient who meets the standard for IOP services according to the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider such as: <ul style="list-style-type: none"> • Moderate or severe opioid use disorder; • Significant psychological or social challenges; • Failure to successfully initiate treatment in previous attempt; • Relapse after previous treatment; and/or • Lack of solid social supports

Payments for psychotherapy, counseling, and social services related to initiation of treatment would be made separately under current payment systems or under alternative payment models specifically designed to more effectively support those services.

Other services related to addiction –emergency department visits, hospitalizations, etc. – that are received by the patient during the month in which the IMAT payment is billed would also be paid for separately from the IMAT payment. Service such as laboratory testing or medication dispensing are not a part of the services described in this model but may be a part of a reasonable and appropriate part of a payment structure negotiated by payers and providers. If a patient

required intensive (inpatient) withdrawal management before they could initiate medication-assisted treatment, the withdrawal management services would be paid for using current payment methods or a different alternative payment model. Payments for treatment of conditions other than addiction, including medical or psychiatric complications of substance use, would continue to be made in addition to the IMAT payments.

Option C: C-IMAT Payments for Comprehensive Services

This option would be used where a single organization serves as the Opioid Addiction Team and employs or contracts with the necessary personnel to prescribe medications, deliver psychiatric, psychological, or counseling services, address non-medical needs, and provide care management services for individuals with an opioid use disorder. This organization could either be:

- a physician practice that is prescribing and supervising the medical treatment, which would then distribute portions of the C-IMAT payment to the other providers on the Opioid Addiction Treatment Team who are delivering the other services under the terms of contracts between the physician practice and those other providers;
- an organizational entity formed by the members of the Opioid Addiction Treatment Team for the purposes of sharing the C-IMAT payment to deliver integrated addiction treatment services; or
- an organization that employs all the personnel needed to serve as an Opioid Addiction Treatment Team.

Under this option, the organization could bill for and receive a single, bundled Comprehensive IMAT (C-IMAT) payment to support the following addiction treatment-related services for an eligible patient during treatment planning and the 30 days following initiation of treatment:

- induction of buprenorphine or naltrexone treatment;
- psychological support services; and
- Appropriate coordination of services such as care management, social support, and other necessary medical services to treat the patient's condition.

The organization that bills for a C-IMAT payment would not bill or be paid separately for any of the above services that are related to opioid addiction treatment during the month in which the IMAT Payment is billed. Other services related to addiction – laboratory tests, emergency department visits, hospitalizations, etc. – that are received by the patient during the month in which the IMAT payment is billed would still be paid for separately from the IMAT payment. If a patient required withdrawal management before they could initiate medication-assisted treatment, the withdrawal management services would be paid for using current payment methods or a different alternative payment model. Payments for treatment of conditions other than addiction, including medical or psychiatric complications of substance use, would continue to be made in addition to the IMAT payments.

The C-IMAT Payment would only replace E/M payments for those office visits related to addiction treatment. If a patient with addiction visits the practitioner who is delivering medication-assisted treatment for a health problem other than addiction, that visit and any other services related to that problem would be paid for separately under the regular physician fee schedule (or under an alternative payment model designed for those other health problems), even if the visit or service occurred on the same day as a visit for addiction-related care.

As shown in Table 3, a higher amount would be paid for patients with specific characteristics that the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider indicate should receive more intensive medical supervision, counseling, social services, or care coordination to successfully initiate treatment.

TABLE 3
OPTION C: Comprehensive Payment for Initiation of
Medication-Assisted Treatment (C-IMAT)

Category	Billing Code	Patient Characteristics
Initiation of Level 1 Comprehensive Outpatient Medication-Assisted Treatment Services	xxx16	A patient who does not have characteristics requiring more intensive levels of service
Initiation of Level 2 Intensive Comprehensive Outpatient Medication-Assisted Treatment Services	xxx17	A patient who meets the requirements for placement in an IOP level of service according to the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider, such as: <ul style="list-style-type: none"> • Moderate or severe opioid use disorder diagnosis; • Significant psychological or social challenges; • Failure to successfully initiate treatment in a previous attempt; • Relapse after previous episodes of treatment; and/or • Lack of solid social supports

Payments for Technology-based Treatment and Recovery Support Tool:

In addition to the above options, Opioid Addiction Treatment Teams that use technology-based treatment and recovery support tools would be eligible for an add-on payment approximately equal to 5-10% of the standard payment. This payment may be temporary to support testing and startup costs and may be negotiated to reflect actual costs after initiation and utilization of the tool.

1.3. Accountability for Quality and Outcomes

A physician practice receiving Initiation of Medication-Assisted Treatment Payments would be accountable for the quality and outcomes of the care delivered to the patients with support from the IMAT Payments.

Minimum Quality Standards

The physicians, clinicians, and other providers on the Opioid Addiction Treatment Team would attest that they had met or would meet the following standards when they bill for the IMAT Payment for a patient. Insurers will be allowed to perform reviews at any time to ensure these standards are being met. Failure to meet any of the standards for a patient would mean the physician practice could not bill for an IMAT Payment for that patient.

- Documentation of a diagnosis of opioid use disorder;
- Screening using a validated screening tool for substance use disorders, including tobacco use disorder, psychiatric disorders, and other comorbidities that may affect treatment before developing a Treatment Plan;
- A face-to-face visit between the patient and the prescribing physician or clinician using a shared decision-making process to develop and agree on a written Treatment Plan that describes the types and frequency of treatment and services the patient should receive, including medications and laboratory tests;
- Determination of the appropriate Level of Care for the patient consistent with the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider and documentation of the basis for that determination;
- Documentation that the Treatment Plan is consistent with the Standards of Care established by the American Society of Addiction Medicine, or other equivalently evidence-based widely used document, and documentation of the reasons for deviation from the Standards;
- Initiation of medication-assisted treatment;
- A face-to-face visit between the patient and the prescribing physician or clinician within 7-10 days after initiation of medication-assisted treatment for patients receiving Level 1 treatment;²⁵
- Checking the state's Prescription Drug Monitoring Program (PDMP) to determine whether other medications have been prescribed and whether the patient has filled prescribed medications;
- Documentation that laboratory tests are consistent with the ASAM Appropriate Use of Drug Testing Document, or other such equivalent, evidence-based, widely used document, and are performed within 30 days of initiation of treatment to assess whether the patient is using the prescribed medications and is not using opioids or other illicit drugs;
- Coordination with other addiction-related services the patient is receiving;
- Communication with other physicians and providers to coordinate addiction-related services with non-addiction-related services the patient is receiving;
- Revisions to the written Treatment Plan if necessary following initiation of treatment; and

- Scheduling or verification of scheduling of visits with one or more physicians or other providers for maintenance of medication-assisted treatment.
- To be eligible for payment for technology-based treatment and recovery support tools, remote monitoring and/or services that are used in conjunction with standard outpatient treatment for opioid addiction must have certain minimal functionalities, descriptions and validation criteria to support their use.

Performance Measures Related to Care Quality, Spending and Outcomes²⁶

The physician practice's performance would be assessed on the following measures:

- Initiation of Treatment Measure 1: % of patients who filled²⁷ and used the medications prescribed to initiate treatment;
- Initiation of Treatment Measure 2: % of patients who demonstrated compliance by only taking medications that are part of the written treatment plan (as determined through testing and testing claims data);²⁸
- Utilization of Services Measure 1: % of patients whose opioid and other drug-related laboratory testing during initiation of treatment is consistent with the ASAM Appropriate Use of Drug Testing Document or other equivalent evidence-based, widely used documents; and
- Utilization of Services Measure 2: risk-adjusted average number of opioid-related emergency department visits per patient

[More detailed specifications for the measures will need to be developed.]

Each measure would be calculated separately for patients receiving Level 1 and Level 2 outpatient services. If multiple physician practices are part of the same OATT, they could elect to have their performance measured jointly.

Assessment of Performance

The physician practice's performance on each measure would be compared to the average performance on that measure of all practices receiving the payment during the prior year for the same category of patients. If the practice's performance was within two standard deviations around the average on a measure, the practice's performance on that measure would be deemed "good performance." If performance was significantly better than this range, it would be deemed "excellent" and if it was significantly worse, it would be deemed "poor." Under this methodology, most physician practices would be expected to receive a rating of "good performance" on the measures if they are following accepted practices.

Adjustment of Payment Based on Performance

The physician practice would receive the default amounts for the IMAT Payments in each level of care if its performance during the most recent measurement period was "good" on all the measures for the patients it treated in that level of care. The payment would be increased if all measures were "good" and some were "excellent," and the payment would be reduced if some measures were "poor."

TABLE 4
Performance-Based Adjustments to IMAT Payments

	Performance on Successful Initiation of Treatment		
Performance on Utilization of Services:	Poor on Either Measure	Good on Both Measures	Excellent on Both Measures
Poor on Either Measure	-4%	-2%	0%
Good on Both Measures	-2%	0%	+2%
Excellent on One and Good on Other	0%	+2%	+4%

Since most physician practices would be expected to be rated as “good” on all measures, most practices would receive the standard payment amounts with no adjustments. The standard payment amounts would be set at levels that are adequate to cover the costs of delivering high-quality care.

2. Maintenance of Medication-Assisted Treatment (MMAT)

2.1. Eligible Patients

A physician practice that is part of an OATT could receive a monthly Maintenance of Medication-Assisted Treatment (MMAT) Payment for continued treatment of a patient who had successfully completed a month of treatment supported by an IMAT Payment or who had initiated treatment in an inpatient setting or residential facility and now has a Treatment Plan indicating that outpatient treatment is appropriate.

The Opioid Addiction Team as a whole, or the specific physicians and other providers who are delivering services to the patient, could be different than the Team or the physicians and other providers who provided services during the initiation of treatment as long as the patient agreed to the transition and the physicians and other providers involved in the two phases of care documented that they had communicated directly with each other to assure a smooth transition for the patient.

In order for the physician practice to receive a monthly MMAT Payment for a patient, and in order for the patient to benefit from the enhanced services available through the payment, the patient would need to explicitly agree to receive all of their addiction-related services from the members of the Opioid Addiction Treatment Team that the physician practice was a part of, or from other providers designated by the Team, during the month.

Before agreeing to serve as a patient's Opioid Addiction Treatment Team, the Team could ask the patient to commit to follow the treatment plan and take other specific types of actions designed to maximize the Team's ability to deliver care that achieves the best possible outcomes at the most affordable cost. This model does not exclude participation by special populations, including pregnant women. However, providers may choose to exclude from this model those patients who have more complex needs or may need a different level of service not provided by this model. Providers may work with insurers to ensure that this model works for special populations or may decide to use existing payment methods or other APMs to cover these patients.

2.2. Structure of Payments and Services Covered

As with the IMAT payments, there would be three different options for MMAT Payments to support different service delivery structures:

Option A: MM-MMAT Payments for Medical Management by a DATA 2000 Practitioner

This option would be used for a practitioner who:

- is not an Addiction Specialist Physician;
- has received a prescribing waiver under the Drug Addiction Treatment Act of 2000 (DATA 2000);
- is prescribing and supervising the patient's medication therapy;
- has a collaborative agreement with an Addiction Specialist Physician (when available and feasible) to provide consultative support if DATA 2000 provider sees patients who qualify for IOP care;

- has a collaborative agreement with other providers or organizations to deliver psychological/counseling and social services support; and
- is coordinating all the addiction-related services the patient is receiving and coordinates those services with any non-addiction related services the patient is receiving.

As shown in Table 5, the DATA 2000 practitioner could bill for and receive monthly Medical Management for Maintenance of Medication-Assisted Treatment (MM-MMAT) payments for delivering ASAM Level 1 office-based medication therapy and care coordination. The payments would be higher during the initial twelve months of treatment (billing code xxx22) and lower for patients who had successfully completed twelve months of treatment (billing code xxx22). If a patient had successfully completed at least twelve months of Level 1 treatment and wanted to attempt supervised termination of treatment, the practitioner could bill for services at the higher rate (billing code xxx22) for up to 12 months while supervising the termination of treatment.

The DATA 2000 practitioner could still bill for and receive standard Evaluation & Management Services (E/M) payments for face-to-face visits with the patient in addition to the MM-MMAT payment, but the practitioner would not bill for other non-face-to-face care management or collaborative care services during the month in which the MM-MMAT payment was made. Payments for treatment of conditions other than addiction, including medical or psychiatric complications of substance use, would continue to be made in addition to the MMAT payments.

In general, a DATA 2000 practitioner would not deliver medication therapy for patients requiring ASAM Level 2 IOP services, but would refer such patients to an Addiction Specialist when available and feasible, who would be paid for those services under Option B. However, if an Addiction Specialist is not available to treat the patient but is available for consultation with the DATA 2000 physician, the DATA 2000 physician could bill for and be paid a higher amount for those patients using billing code xxx23.

The Addiction Specialist Physician could bill for and receive a separate Addiction Specialist MMAT Consultation payment (billing code xxx24) if a consultation was provided to the DATA 2000 practitioner to assist with the assessment and treatment planning process. Only one Consultation payment could be paid during the month in which treatment was being initiated.

TABLE 5
OPTION A: Medical Management Payment for Maintenance of
Medication-Assisted Treatment (MM-MMAT) by a DATA 2000 Practitioner

Category	Billing Code	Patient Characteristics
Long-Term Maintenance of Level 1 Outpatient Medical Management	xxx21	Medical management services provided by either a DATA 2000 practitioner or an Addiction Specialist for a patient who has successfully completed 12 months of treatment and who meets the standard for outpatient services according to the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider. .
Maintenance of Level 1 Outpatient Medical Management by a DATA 2000 Practitioner	xxx22	Medical management services provided by a DATA 2000 practitioner for a patient who: <ul style="list-style-type: none"> • has not yet completed 12 months of treatment and who meets the standard for outpatient services according to the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider; or • a patient who wishes to attempt supervised termination of treatment
Maintenance of Level 2 Outpatient Medical Management by a DATA 2000 Practitioner	xxx23	Medical management services provided by a DATA 2000 practitioner for a patient who meets the standard for IOP services according to the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider if an Addiction Specialist is not available to directly treat the patient
Addiction Specialist MMAT Consultation	xxx24	Support by an Addiction Specialist for a DATA 2000 practitioner providing medical management services for IMAT (only one payment per month)

The MM-MMAT would be intended to provide sufficient additional resources to the DATA 2000 practitioner and the Addiction Specialist to support successful:

- continuation of buprenorphine or naltrexone treatment; and
- care management services for the patient and coordination of addiction services with other services the patient is receiving for other conditions from other physicians and providers.

Payments for psychotherapy, counseling, and social services related to maintenance of treatment would be made separately under current payment systems or under alternative payment models specifically designed to more effectively support those services if they were part of the patient's Treatment Plan and delivered by members of the OATT.

Other services related to addiction –, emergency department visits, hospitalizations, etc. – that are received by the patient during the month in which the MMAT payment is billed would also be paid for separately from the MMAT payment. Services such as laboratory testing or medication dispensing are not a part of the services described in this model but may be a part of a reasonable and appropriate part of a payment structure negotiated by payers and providers. Payments for treatment of conditions other than addiction, including medical or psychiatric complications of substance use, would continue to be made in addition to the MMAT payments.

Option B: MM-MMAT Payments for Medical Management by an Addiction Specialist

This option would be used for a physician who is an Addiction Specialist and is prescribing and supervising the patient’s medication therapy. As shown in Table 6, the Addiction Specialist could bill for and receive monthly Medical Management for Initiation of Medication-Assisted Treatment (MM-IMAT) payments for delivering either ASAM Level 1 or Level 2 office-based medication therapy and care coordination. The payment for Level 2 services (billing code xxx26) would be higher than the payment for Level 1 services (billing code xxx25), and these payments would be greater than or equal to the sum of the corresponding DATA 2000 MMAT and Addiction Specialist MMAT Consultation payments. In addition, the payments for Level 1 services would be higher during the initial twelve months of treatment (billing code xxx25) and lower for patients who had successfully completed twelve months of treatment (billing code xxx21). If a patient had successfully completed at least twelve months of Level 1 treatment and wanted to attempt supervised termination of treatment, the Addiction Specialist could bill for services at the higher rate (billing code xxx25) for up to 12 months while supervising the termination of treatment.

The Addiction Specialist could still bill for and receive standard Evaluation & Management Services (E/M) payments for face-to-face visits with the patient in addition to the MM-MMAT payment, but the Addiction Specialist would not bill for other non-face-to-face care management or collaborative care services during the month in which the MM-MMAT payment was made.

**TABLE 6
OPTION B: Medical Management Payment for Maintenance of
Medication-Assisted Treatment (MM-MMAT) by an Addiction Specialist**

Category	Billing Code	Patient Characteristics
Long-Term Maintenance of Level 1 Outpatient Medical Management	xxx21	Medical management services provided by either a DATA 2000 practitioner or an Addiction Specialist for a patient who has successfully completed 12 months of treatment and who meets the standards for outpatient services according to the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider.
Maintenance of Level 1 Outpatient Medical Management by an Addiction Specialist	xxx25	Medical management services provided by an Addiction Specialist for a patient who: <ul style="list-style-type: none"> • has not yet completed 12 months of treatment and who meets the standards for outpatient services according to the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider; or • a patient who wishes to attempt supervised termination of treatment
Maintenance of Level 2 Outpatient Medical Management	xxx26	Medical management services provided by an Addiction Specialist for a patient who meets the standards for IOP services according to the ASAM Criteria or other equivalently evidence-based

Category	Billing Code	Patient Characteristics
by an Addiction Specialist		standards mutually agreed to by the payer and provider such as: <ul style="list-style-type: none"> • Moderate or severe opioid use disorder; • Significant psychological or social challenges; • Previous failure to continue treatment; and/or • Lack of solid social supports

Option C: C-MMAT Payments for Comprehensive Services

This option would be used for a single organization that serves as the Opioid Addiction Team and employs or contracts with the necessary personnel to prescribe medications, deliver counseling services, address non-medical needs, and provide care management services for individuals with an opioid use disorder. This organization could either be:

- a physician practice that is prescribing and supervising the medical treatment, which would then distribute portions of the C-MMAT payment to the other providers on the Opioid Addiction Treatment Team who are delivering the other services under the terms of contracts between the physician practice and those other providers;
- an organizational entity formed by the members of the Opioid Addiction Treatment Team for the purposes of sharing the C-MMAT payments to deliver integrated addiction treatment services; or
- an organization that employs all the personnel needed to serve as an Opioid Addiction Treatment Team.

Under this option, the organization could bill for and receive a single, bundled Comprehensive MMAT (C-MMAT) payment to support the following services during a month of treatment:

- continued buprenorphine or naltrexone treatment;
- psychological support services;

Appropriate coordination of services such as care management, social support, and other necessary medical services to treat the patient’s condition. The organization that bills for a C-MMAT payment would not bill or be paid separately for any of the above services to the patient that are related to opioid addiction treatment during the month in which the MMAT Payment is billed. Other services related to addiction – laboratory tests, emergency department visits, hospitalizations, etc. – that are received by the patient during the month covered by the MMAT payments would be paid separately. Payments for treatment of conditions other than addiction, including medical or psychiatric complications of substance use, would continue to be made in addition to the MMAT payments.

The C-MMAT Payment would only replace E/M payments for those office visits related to addiction treatment. If a patient with addiction visits the physician or practitioner who is delivering medication-assisted treatment for a health problem other than addiction, that visit and any other services related to that problem would be paid for separately under the regular physician fee schedule (or under an alternative payment model designed for those other health problems), even if the visit or service occurred on the same day as a visit for addiction-related care.

As shown in Table 7, a higher amount would be paid for patients with specific characteristics consistent with the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider that indicate the patient should receive more intensive medical supervision, counseling, social services, or care coordination to successfully initiate treatment. A lower amount would be paid after a patient successfully completed one year of treatment, unless there were patient-specific factors that justified the continuation of a higher-level of services. A higher amount would also be paid for up to 12 months if the patient had been successfully receiving treatment for at least 12 months and the patient wanted to undergo supervised termination of treatment.

The Opioid Addiction Team would assign the patient to the most appropriate service level defined in Table 7 during each month. The Team would be required to document that it had reassessed the patient’s needs at least every 90 days to determine the most appropriate level of service.

TABLE 7
OPTION C: Comprehensive Payment for Maintenance of Medication-Assisted Treatment (C-MMAT)

Category	Billing Code	Patient Characteristics
Long-Term Level 1 Comprehensive Outpatient Medication-Assisted Treatment Services	xxx27	A patient who has successfully completed 12 months of treatment and who does not have characteristics requiring more intense levels of service to continue treatment
Maintenance of Level 1 Comprehensive Outpatient Medication-Assisted Treatment Services	xxx28	A patient who: <ul style="list-style-type: none"> • has not yet completed 12 months of treatment and who does not have characteristics requiring more intense levels of service to continue treatment; OR • has completed 12 months of treatment and wishes to attempt supervised termination of treatment
Maintenance of Level 2 Intensive Comprehensive Outpatient Medication-Assisted Treatment Services	xxx29	A patient who has characteristics indicating the need for IOP according to the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider: <ul style="list-style-type: none"> • Moderate or severe opioid use disorder; • Significant psychological or social challenges; • Previous failure to continue treatment; and/or • Lack of solid social supports

Payments for Technology-based Treatment and Recovery Support Tool:

In addition to the above options, Opioid Addiction Treatment Teams that use technology-based treatment and recovery support tools would be eligible for an add-on payment approximately equal to 5-10% of the standard payment. This payment may be temporary to support testing and startup costs and may be negotiated to reflect actual costs after initiation and utilization of the tool.

2.3. Accountability for Quality and Outcomes

A physician practice receiving Maintenance of Medication-Assisted Treatment Payments would be accountable for the quality and outcomes of the care delivered to the patients with support from the MMAT Payments.

Minimum Quality Standards

The physicians, clinicians, and other providers on the OATT would attest that they have met or will meet the following standards when they bill for the MMAT Payment for a patient. Insurers will be allowed to perform reviews at any time to ensure these standards are being met. Failure to meet any of the standards for a patient would mean the physician practice could not bill for an MMAT Payment for that patient.

- Re-determination of the appropriate Level of Care for the patient consistent with the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider at least every 90 days, and documentation of the basis for that determination;
- A face-to-face visit between the patient and the prescribing physician or clinician at least once every 3 months for patients receiving Level 1 services, and a face-to-face visit during the month covered by the payment for patients receiving Level 2 services;
- Documentation that the treatment that was provided to the patient followed evidence-based widely used documents, such as the Standards of Care from the American Society of Addiction Medicine, or documentation of the reasons for deviation from the Standards;
- Checking the state's Prescription Drug Monitoring Program (PDMP) to determine whether other medications have been prescribed and whether the patient has filled prescribed medications;
- Documentation of orders for laboratory tests to assess whether the patient is using the prescribed medications (and is not using opioids or other illicit drugs) that are consistent with evidence-based widely used documents, such as the ASAM Appropriate Use of Drug Testing Document;
- Coordination with other addiction-related services the patient is receiving;
- Communication with other physicians and providers to coordinate addiction-related services with non-addiction-related services the patient is receiving;
- Revisions to the written Treatment Plan if necessary; and
- Scheduling or verification of scheduling of visits with one or more physicians or other providers for maintenance of medication-assisted treatment.
- To be eligible for payment for technology-based treatment and recovery support tools, remote monitoring and/or services that are used in conjunction with standard outpatient treatment for opioid addiction must have certain minimal functionalities, descriptions and validation criteria to support their use.

Performance Measures Related to Care Quality, Spending and Outcomes²⁹

The practice's performance would be assessed on the following measures:

- Maintenance of Treatment Measure 1: % of patients who filled³⁰ and used prescribed medications throughout the month (except for patients who terminated treatment through a supervised process)
- Maintenance of Treatment Measure 2: % of patients who demonstrated compliance by only taking medications that are part of the written treatment plan at the end of the month (as seen in testing and testing claims data)³¹
- Utilization of Services Measure 1: % of patients whose opioid and other drug-related laboratory testing during initiation of treatment is consistent with evidence-based widely used documents, such the ASAM Appropriate Use of Drug Testing Document
- Utilization of Services Measure 2: the risk-adjusted average number of opioid-related emergency department visits per patient

Each measure would be calculated separately for patients receiving Level 1 and Level 2 outpatient services. If multiple physician practices are part of the same Opioid Addiction Treatment Team, they could elect to have their performance measured jointly.

Assessment of Performance

Performance on each of the measures would be determined by comparing the physician practice’s performance to the average performance on that measure to similar size practices (or Opioid Addiction Treatment Teams) receiving the payment during the prior year for each category of patients. If the practice’s performance was within two standard deviations around the average on a measure, the practice’s performance would be deemed “good performance.” If performance was significantly better than this range, it would be deemed “excellent” and if it was significantly worse, it would be deemed “poor.” Under this methodology, most physician practices would be expected to receive a rating of “good performance” on the measures if they are following accepted practices.

Adjustment of Payment Based on Performance

The physician practice would receive the default amount for the MMAT Payment if its performance during the most recent measurement period was “good” on all the measures for the patients in the category for which that payment was made. The payment would be increased if all measures were “good” and one was “excellent,” and the payment would be reduced if one or more measures were “poor.”

**TABLE 8
Performance-Based Adjustments to MMAT Payment**

	Performance on Successful Maintenance of Treatment		
Performance on Utilization	Poor on Either Measure	Good on Both Measures³²	Excellent on Both Measures
Poor on Either Measure	-4%	-2%	0%
Good on Both Measures	-2%	0%	+2%
Excellent on One and Good on Other	0%	+2%	+4%

Since most physician practices would be expected to be rated as “good” on all measures, most practices would receive the standard payment amounts with no adjustments. The standard

payment amounts would be set at levels that are adequate to cover the costs of delivering high-quality care.

Advanced APM Accountability Option

A physician practice receiving MMAT payments would have the option of accepting accountability for a payer's total spending on opioid use-related services used by the practice's patients. Under this option:

- At the beginning of each year, the payer would calculate its Expected Average Per Patient Per Month Spending on Opioid Use-Related Services for patients with opioid use disorder for the coming year. This would be done by:
 - calculating the average monthly utilization of each opioid use-related service during the prior year for patients who (a) live in the state or region in which the practice is located, (b) received any opioid use-related service during the prior year, and (c) did not receive MMAT services from any practice during the year;
 - multiplying each utilization amount by the amounts the payer expected to pay for each such service during the current year, and
 - summing the products.
- The Target Per Patient Per Month Spending amount would be calculated by taking 97% of the Expected Average Per Patient Per Month Spending amount.
- At the end of the year, all the patients for whom the practice had received MMAT payments from the payer during the year would be identified, and the Actual Average Per Patient Per Month Opioid Use-Related Spending for those patients would be calculated as follows:
 - All the healthcare services the patients received during the month in which the MMAT payment was billed would be identified.
 - Services unrelated to opioid use disorder would be excluded, and the payer's spending on the remaining services would be summed.
 - If an MMAT payment was billed in one month, no MMAT payment was billed for the patient in the following month, but an MMAT payment was billed for the patient in the next month, then the services and spending related to opioid use disorder for all three months would be included. (This avoids any incentive to avoid accountability for a patient in a month in which the patient receives expensive services.)
 - The total spending amount would be divided by the total number of patient-months for which spending was measured.
- If the practice's Actual Average Per Patient Per Month Opioid Use-Related Spending for the payer exceed the payer's Target Per Patient Per Month Spending amount, then:
 - If the practice's performance was Good or Excellent on all four of the Maintenance of Treatment and Utilization of Services Measures defined earlier, the practice would be responsible for making a payment to the payer equal to either (a) 30% of the difference between the Actual Average and Target Spending Amount, (b) 4% of the Target Spending or (c) 8% of the practice's total revenues from the payer during the year, whichever is less.
 - If the practice's performance was Poor on two or more of the Measures, the practice would be responsible for making a payment to the payer equal to either (a) 50% of the

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- difference between the Actual Average and Target Spending Amount, (b) 5% of the Target Spending or (c) 9% of the practice's total revenues from the payer during the year, whichever is less.
- If the practice's Actual Average Per Patient Per Month Opioid Use-Related Spending for the payer was less than the payer's Target Per Patient Per Month Spending amount, then:
 - If the practice's performance was Good or Excellent on all four of the Maintenance of Treatment and Utilization of Services Measures defined earlier, the payer would pay the practice an additional amount equal to either (a) 50% of the difference between the Actual Average and Target Spending Amount, or (b) 4% of the Target Spending, whichever is less.
 - If the practice's performance was Poor on one or two of the Measures, the payer would pay the practice an additional amount equal to either (a) 30% of the difference between the Actual Average and Target Spending Amount or (b) 2% of the Target Spending, whichever is less.
 - If the practice's performance was Poor on more than two Measures, the practice would not receive any additional payment beyond the amount calculated based on the Measures alone.

IV. Setting and Adjusting Payment Amounts

A default payment amount would be established for each of the service codes defined in Section III. These payment amounts would be defined in advance, similar to a standard fee schedule, so that physicians and other members of Opioid Addiction Treatment Teams would know what they would be paid for delivering the services defined in a phase of care to patients who meet the characteristics for the service code within that category.

The payment amounts would be designed to achieve three goals:

- **Provide adequate resources to support the services patients need for high-quality care and good outcomes.** The amount of payment for each subcategory of patients should be adequate to support the time and costs that the physicians and other providers would need to spend for patients with the characteristics associated with the subcategory during the relevant phase of patient care.
- **Avoid losses of revenue to high-quality, efficient practices.** The aggregate amount of net revenue that a high-quality, efficient physician practice would receive under the new payment system from a participating payer should be greater than or equal to the aggregate amount of revenue that the practice would have received from that payer under the current payment system. There may be some shift in revenues from one subcategory of patients to another if the current payment system provides higher payments relative to costs in one subcategory than another.
- **Budget neutrality/savings/slower spending trend for payers.** The total spending by the payer on addiction treatment for the patients in all participating physician practices, considering both what is paid to the practices and what is paid for other costs of addiction-related services to the practices' patients (e.g., laboratory testing, emergency room visits, hospitalizations, drugs, etc.) should be no greater than what would be projected under the current payment system, and ideally result in lower overall spending than would have otherwise been expected on a per-patient basis, over a multi-year period.

V. Method of Billing and Payment

For each of the payments described in Section III, the physician practice or organization providing MAT would submit a claim to the patient's health insurance plan (or a bill to the patient, if the patient has no insurance) using one of the "condition based payment codes" described in Tables 1, 2, 3, 5, 6, and 7 that matches the patient's phase of care, the patient's characteristics, and the provider's characteristics and services delivered. The claim with this code could be billed to the payer using the practitioner's existing billing system, and the claim could be paid by the payer using its existing claims payment system, similar to what is done today with claims forms billed using existing CPT codes. The payer would reject any claims for services to the patient that are explicitly precluded for separate billing if those claims are submitted by the providers on the OATT or by providers who are not on the Team.

Submission of the claim would represent a certification by the practitioner that:

- The patient has characteristics that qualify them for the subcategory associated with the condition-based payment code that is shown on the claim form;
- The DATA 2000 practitioner and/or addiction specialist and the other members of the OATT are meeting all minimum standards for services and delivering all appropriate services for the phase of care and the characteristics of the patient associated with the condition-based payment code that is shown on the claim form; and
- The physician practice or organization accepts the payment associated with that payment code as payment in full for all the types of addiction-related services covered by the payment during the period defined by the payment.

The payer receiving the claim will determine the standard payment amount for the code on the claim form that is specified in the contract between the payer and the physician practice, and it will adjust the payment by the performance adjustment factor for the practice that is determined using the methodologies described in Section III. In general, the performance adjustment factor would be established on an annual basis based on the physician practice's performance in the prior year. Physician practices or organizations with larger numbers of patients could potentially have their performance adjustment factors updated more frequently (e.g., semiannually or quarterly), whereas practices with fewer patients could have their performance measured over a longer period (e.g., two years) to have more reliable measures with smaller numbers of patients.

If multiple providers are working together as an Opioid Addiction Treatment Team to manage patient care (e.g., a primary care practice, an addiction specialist, and a behavioral health agency) and are accepting Comprehensive IMAT or MMAT payments for their services, then those providers would be permitted to determine how the bundled C-IMAT and C-MMAT payments defined in Section III would be divided among them. The providers could either agree that one provider will receive the payments and then make the allocations to the other provider(s), or the providers could form a separate corporate entity (e.g., a limited liability company) controlled by the participating providers and the payer would make the payments to that entity. (This entity could serve as an "alternative payment entity" under MACRA.)

V. P-COAT in Practice

New Patient

A 42-year-old man is taken to the emergency department due to an opioid poisoning. After being stabilized, he is referred to a physician practice/organization capable of directly delivering medical, psychological, and social services. Under the comprehensive Initiation of Medication-Assisted Treatment (IMAT) payment, the practice receives a one-time IMAT payment to conduct an evaluation and comprehensive assessment consistent with the ASAM Criteria or other equivalently evidence-based standards mutually agreed to by the payer and provider. The physician will confer with the patient to create a treatment plan consistent with the ASAM Levels 1 and 2 that utilizes medication in combination with psychosocial supports.

Established Patient – Relapse after 6 Months, Medical Management Scenario

Although a 22-year-old pregnant woman initially began maintenance treatment under a treatment plan about six months ago, she shows up to the emergency department due to an opioid poisoning. After being stabilized, she is referred to her OBGYN to develop a new treatment plan. In addition to the IMAT payment the physician received for the first treatment plan, another one-time IMAT payment will be made to cover the new treatment planning, medication induction, and care coordination needed to reengage in care since 6 months have elapsed. Since the physician isn't equipped to provide the full scope of med/psychological/social care, all behavioral and social services coordinated by the physician are delivered and paid for separately according to current payment methods.

Established Patient – Treatment Disengagement within 6 Months, Comprehensive Team Scenario

A screening for a 68-year-old woman who has been prescribed opioid analgesics for chronic pain for several years indicates a likely substance use disorder. The prescriber has already been paid an IMAT payment to create a treatment plan and begin treatment, but the patient disengaged three months into treatment. Her primary care doctor is a part of a fully integrated opioid addiction treatment team that offers medical/psychological/social services. Since the treatment team has already received a one-time IMAT payment during a six-month period to support the development of a treatment plan and treatment itself, the patient is reengaged in treatment through monthly MMAT payments to the team to cover costs of treatment.

Patient with Other Chronic Diseases, Managed by Addiction Specialist

A 56-year-old veteran who has been managed with MAT involving buprenorphine for 22 months experiences a relapse and uses heroin. He also has diabetes and chronic lower back pain. The addiction specialist works with the patient to develop a new treatment plan and coordinate behavioral therapy and social services which will be covered in a one-time IMAT payment for treatment plan development and initiation of treatment. The addiction specialist would work with the patient's primary physician to manage his diabetes and lower back pain and would receive a higher IMAT payment to reflect the increased time and level of complexity associated with consulting with the patient's primary caregiver to manage his comorbidities.

New Patient

A 32-year-old political consultant has been using non-prescription pain killers and now has an OUD. After exhausting his non-prescription pain killers, he visits his primary care doctor to obtain prescription opioid pain killers. His doctor performs a comprehensive assessment, the

patient is diagnosed with an opioid use disorder and treatment begins as part of a treatment plan under the IMAT payment arrangement. The patient is stabilized, successfully stops the use of illicit opioids, and sees his primary care doctor once a month as part of the MMAT payment arrangement to maintain continuity of pharmacotherapy with psychosocial supports.

Payment Adjustment Example

During the last performance year, a physician's comprehensive team achieved an "excellent" performance on both the ED visit rate and the "successful initiation of treatment" metrics. The team will receive an 4% increase in the payment amounts for evaluating, assessing, creating a treatment plan, and initiating treatment for patients during the next performance period.

Treatment Using Naltrexone

A 16-year-old patient who has been using heroin for almost seven months is diagnosed with opioid use disorder. His primary care doctor begins withdrawal management before starting the patient on naltrexone. Once withdraw management is complete, the physician will be paid a monthly MMAT payment to manage the patient's treatment using naltrexone, behavioral therapy, and social support services. The cost of withdrawal management will continue to be paid using current payment methods.

Advanced APM Option

Step 1

At the beginning of the year, calculate **Expected Average Per Patient Per Month (EAPPM)** spending for patients that received OUD-related care during the previous year, but did not receive care payed for by MMAT payments.

EAPPM spending = **SUM** (AVG Monthly Utilization for each OUD-related service during prior year (**X**) Expected Payment Amount per Service).

Step 2:

Calculate **Target Per Patient Per Month (TPPM)** spending.

TPPM Spending = **97% of EAPPM**

Step 3:

At the end of the year, calculate **Actual Average Per Patient Per Month (AAPPM)** spending for OUD-related services in months in which the practice billed for an MMAT payment, and for months with no MMAT payment in between two months when there was an MMAT payment. Exclude services unrelated to OUD.

AAPPM Spending = Total spending on OUD-related services (÷) total patient-months

Step 4:

Compare AAPPM Spending to TPPM Spending and then arrange to bill practice for the difference or make payment to the practice for the difference.

Performance on Performance Measures	AAPPM Spending > TPPM Spending	AAPPM Spending < TPPM Spending
Good/Excellent on all Measures	Practice pays to payer: <ul style="list-style-type: none"> • 30% of the difference, • 4% of the Target Spending, or • 8% of the practice’s total revenues from the payer during the year, whichever is less. 	Payer pays to practice: <ul style="list-style-type: none"> • 50% of the difference, or • 4% of the Target Spending, whichever is less.
Poor on 1 measure	No adjustment	Payer pays to practice: <ul style="list-style-type: none"> • 30% of the difference, or • 2% of the Target Spending, whichever is less.

<p>Poor on 2 measures</p>	<p>Practice pays to Payer:</p> <ul style="list-style-type: none"> • 50% of the difference, • 5% of the Target Spending, or • 9% of the practice’s total revenues from the payer during the year, whichever is less. 	<p>Payer pays to practice:</p> <ul style="list-style-type: none"> • 30% of the difference, or • 2% of the Target Spending, whichever is less.
<p>Poor on 3 measures</p>	<p>Practice bills Payer:</p> <ul style="list-style-type: none"> • 50% of the difference, • 5% of the Target Spending, or • 9% of the practice’s total revenues from the payer during the year, whichever is less. 	<p>No additional payment</p>
<p>Poor on all 4 measures</p>	<p>Practice pays to Payer:</p> <ul style="list-style-type: none"> • 50% of the difference, • 5% of the Target Spending, or • 9% of the practice’s total revenues from the payer during the year, whichever is less. 	<p>No additional payment</p>

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- ⁴ ASAM notes that there are other terms for medication-assisted treatment (MAT) such as medication-assisted therapy and medication for addiction treatment. For this document, MAT refers to the use of medication in combination with behavioral therapy and social services supports to treat opioid addiction.
- ⁵ “Where Multiple Modes of Medication-Assisted Treatment Are Available,” Health Affairs Blog, January 9, 2018. DOI: 10.1377/hblog20180104.835958
- ⁶ Park-Lee, E., Lipari, R. N., Hedden, S. L., Kroutil, L. A., & Porter, J. D. (2017, September). Receipt of services for substance use and mental health issues among adults: Results from the 2016 National Survey on Drug Use and Health. NSDUH Data Review. Retrieved from <https://www.samhsa.gov/data/>
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- ⁸ “Practitioner” in this document refers to physicians, advance nurse practitioners, and physician assistants who have received a DATA 2000 waiver to prescribe buprenorphine for the treatment of addiction.
- ⁹ Drug Addiction Treatment Act of 2000, 21 USC 801
- ¹⁰ Physician and Program Data. (2017, March 14). Retrieved August 28, 2017, from <https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/physician-program-data>
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- ¹³ Ibid
- ¹⁴ The Drug Addiction Treatment Act of 2000 allows qualified physicians to prescribe controlled substances, such as buprenorphine for the treatment of addiction outside of SAMHSA-regulated opioid treatment programs (OTPs). Prescribing ability was extended to advance nurse practitioners and physician assistants in the Comprehensive Addiction and Treatment Recovery Act (CARA), passed by Congress and signed by the president in 2016.
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- ¹⁷ Information from APM Working Group knowledge and information contained within the U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.
- ¹⁸ The glossary of The ASAM Standards of Care for the Addiction Specialist Physician defines a treatment plan as “[an] individualized plan [that] should be based on a comprehensive biopsychosocial assessment of the patient and, when possible, a comprehensive evaluation of the family, as well.”
- ¹⁹ Knudsen, H. K., Abraham, A. J., & Oser, C. B. (2011). Barriers to the implementation of medication-assisted treatment for substance use disorders: The importance of funding policies and medical infrastructure. *Evaluation and Program Planning*, 34(4), 375–381. <http://doi.org/10.1016/j.evalprogplan.2011.02.004>
- ²⁰ Digital health encompasses a broad scope of tools that engage patients for clinical purposes; collect, organize, interpret and use clinical data; and manage outcomes and other measures of care quality. This includes, but is not limited to, digital solutions involving telemedicine and telehealth, mobile health (mHealth), wearables (e.g., Fitbit), remote monitoring, apps, and others (Digital Health Study Physicians’ motivations and requirements for adopting digital clinical tools. American Medical Association. Retrieved January 2, 2018 from <https://www.ama->

assn.org/sites/default/files/media-browser/specialty%20group/washington/ama-digital-health-report923.pdf). The AMA in their Digital Health Study described seven specific tools: Remote monitoring for efficiency; remote monitoring and management for improved care, clinical decision support, patient engagement, tele-visits/virtual visits, point-of-care/workflow enhancements; and consumer access to clinical data.

²¹ Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews Retrieved January 2, 2018 from <https://effectivehealthcare.ahrq.gov/topics/telehealth/technical-brief/>

²² Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews Retrieved January 2, 2018 from <https://effectivehealthcare.ahrq.gov/topics/telehealth/technical-brief/>

²³ Substance Abuse and Mental Health Services Administration. Federal Guidelines for Opioid Treatment Programs. HHS Publication No. (SMA) XX-XXXX. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

²⁴ Currently only applies to advance nurse practitioners or physician assistants. Other professionals may be allowed to prescribe per changes in federal or state laws.

²⁵ For those providing comprehensive services, meeting with any member of the team on that frequency would qualify (i.e. patient attending IOP would not also need to meet with a medical provider weekly unless medically indicated)

²⁶ To the greatest extent possible, this APM will use existing performance measures that align with the goals of this model. When relevant performance measures do not exist, ASAM will work with the relevant payers to use measures that improve outcomes for those who have an OUD. We understand that CMS may deem a measure to be a quality measures if the agency determines that it has an evidence-based focus and is both reliable and valid. (42 CFR Part 414.1415)

²⁷ Practitioners should use their states' PDMP to the greatest extent possible to verify that medications have been filled

²⁸ Patients are only allowed to take prescribed medications and over the counter medications. This measure is to account for substances found in testing that reveals the presence of non-prescribed and non-over-the-counter substances.

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³² Most practices would be expected to perform in this category.

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