November 20, 2017

Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for Information on New Direction for CMMI

Dear Administrator Verma,

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing more than 5,100 physicians and allied health professionals who specialize in the treatment of addiction, we are pleased to provide comments to the Request for Information (RFI) from the Centers for Medicare and Medicaid Services (CMS) on a new direction for the Centers for Medicare and Medicaid Innovation (CMMI).

As you may know, the Substance Abuse and Mental Health Services Administration (SAMHSA) reports that over 2 million people suffered from opioid addiction in the United States in 2016. At the same time, only about 20% or 500,000 individuals received specialty treatment for addiction that included the use of medication, despite widespread evidence of its safety and effectiveness. This represents a treatment gap of almost two million people. Many factors contribute to the low utility of addiction medication and this treatment gap, including the inadequate reimbursement of coverage for treatment of substance use disorder (SUD) by public and private payers, the bifurcation of medical and behavioral health benefits, and a shortage of well-trained physicians and clinicians to treat opioid addiction.

Combatting these issues requires a new approach that includes adequate reimbursement for addiction care, integrating medical and behavioral health benefits, and increasing the capacity of the addiction medicine workforce to treat addiction. ASAM has led efforts in many of these areas, but a broad coalition of stakeholders is necessary to further advance this cause. We support CMMI principles and ideas that increase access to and improves the quality of addiction treatment and incentivizes care value over volume.

ASAM recognizes the value of involving beneficiaries in the development of APMs via pathways such as public comment periods, and by encouraging participation by making it easier to find highly skilled and

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qualified addiction specialists who participate in APMs. We urge CMS to incorporate a wide array of beneficiaries into their payment models by using all available payment pathways, including through Section 1115(a) waivers. ASAM welcomes CMS' new direction on Section 1115 waivers and we encourage CMS to integrate this new guidance into the guiding principles and the development of payment models to treat addiction.

Given these circumstances, ASAM urges CMS to recognize the need for alternative payment pathways to treat opioid addiction, separate from the current fee-for-service (FFS) model. We welcome efforts by CMS to increase utilization of and access to medications to treat opioid addiction by providing the appropriate financial support to enable physicians and clinicians to successfully treat opioid addiction with medications and therapy; broaden the coordinated delivery of medication, psychological, and social services; and ultimately increase the proportion of individuals with opioid addiction who are successfully treated.

As an example of possible payment models that CMS and CMMI should consider that are in line with the aforementioned principles, ASAM and the American Medical Association (AMA) have made significant progress on the development of the Patient-Centered Opioid Addiction Treatment (P-COAT) APM in response to the increase in the rate of those suffering from an opioid addiction, the underutilization of medication to treat it, and the numerous problems with current payment systems. P-COAT is a two-tiered, bundled, physician specialty APM and is designed to incentive physicians to deliver high quality, evidence-based outpatient addiction treatment to patients. In this model, physicians and other clinicians share risk and are held accountable by evidence-based performance measures while guaranteed provider payments are stratified by provider type and risk-adjusted based on a set of core performance measures.

P-COAT also represents a significant clinical practice transformation. Currently, outpatient treatment practices and protocols continue to use treatments that exclude the use of medication in conjunction with behavioral therapies to treat opioid addiction, despite a wealth of evidence documenting its effectiveness and superiority when compared to other treatments such as abstinence. Additionally, while medication in conjunction with behavioral therapy is a comprehensive and recommended form of treatment for opioid addiction, many health plans continue to pay medical and behavioral health benefits separately. This APM represents a clinical practice transformation by employing a comprehensive, as well as an integrated delivery of care approach that transforms inadequate and siloed provider reimbursement into a bundled payment structure that rewards highly qualified providers who deliver evidence-based treatment.

ASAM also understands that the adoption of models like P-COAT require broad participation. In the example of P-COAT, a broad array of qualified professionals would deliver outpatient care through ASAM Levels of Care 1 (outpatient) and 2 (intensive outpatient). Specifically, physicians, advance nurse practitioners, and physician assistants who are permitted to prescribe medications per The Drug Addiction Treatment Act of 2000 (DATA 2000); physicians who specialize in addiction medicine through the appropriate board examination; and healthcare professionals licensed and certified to provide appropriate psychiatric, psychological, or counseling services would be eligible to participate in P-COAT.

We further encourage CMS to adopt specific quality measures like those in P-COAT that advance choice and competition among providers participating in behavioral health APMs to ensure that patients are getting the best evidence-based care. ASAM included several quality

improvement measures in P-COAT such as documented treatment plans consistent w/ASAM Standards of Care, face-to-face doctor visits within seven days of treatment initiation, and verification that patients filled prescribed medications.

As suggested by its name, the P-COAT APM adheres to CMMI's guiding principle of patient-centered care by improving patients' access to care and allowing the flexibility to choose providers who possess expert knowledge and skills in addiction medicine. Given the gravity of the opioid epidemic and the need to provide patients with evidence-based, quality care, we urge CMS to consider APMs like ASAM's that advance access to quality care by providing appropriate financial support to enable highly qualified clinicians to provide successful treatment.

Additionally, P-COAT supports CMMI's guiding principle of provider choice and incentives through voluntary participation and by providing incentives in the form of positive payment adjustments to clinicians who deliver better outcomes. To facilitate the development of an APM that is supported by a wide array of stakeholders, the P-COAT APM will undergo a rigorous review process that includes both public and private stakeholders. Given the breadth of ideas that ASAM has attracted during this ongoing review phase, ASAM encourages CMS to test models that use the best ideas from a broad range of groups and individuals.

To ensure that patients have access to evidence-based addiction medicine practices and to provide an adequate level of provider reimbursement to combat the underutilization of medication and behavioral therapy to treat opioid addiction, ASAM is open to working with CMS to determine the appropriate size and scale of models needed to yield actionable evidence in reduction of costs and improved quality of care. As CMMI and CMS develops APMs, we encourage the agency to waive burdensome administrative requirements on providers and reevaluate the use of prior authorization, certification, and documentation/reporting requirements that often prevent physicians from spending the majority of their time with patients.

We appreciate the interest that CMS has shown in behavioral health APMs as evidenced by the CMS Behavioral Health Summit in September 2017 and this RFI. P-COAT offers a solution to many of the problems with current payments systems while giving providers the flexibility to work within existing billing systems and infrastructure. Should CMS decide to develop a behavioral health model similar to ASAM's P-COAT APM, it would broaden the agency's portfolio of APMs which are not currently included, and would be a significant clinical practice transformation of the addiction medicine specialty.

Thank you for the opportunity to respond to this RFI. If you have any questions, comments, or concerns, please contact Corey Barton, Manager, ASAM Private Sector Relations at 301-547-4016 or via email at cbarton@asam.org.

Sincerely,

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President, American Society of Addiction Medicine