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Addiction Medicine

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November 1, 2019

The Honorable Greg Walden
Republican Leader
Committee on Energy and Commerce
United States House of
Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Brett Guthrie
Republican Leader, Subcommittee on
Oversight and Investigations
Committee on Energy and Commerce
United States House of
Representatives
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The Honorable Michael C. Burgess, M.D.
Republican Leader, Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Re: Substance Use Disorder Treatment Request for Information

Dear Republican Leaders Walden, Burgess, and Guthrie,

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing over 6,000 physicians and other health professionals who specialize in the prevention and treatment of addiction, thank you for the opportunity to provide ASAM's insights on how our nation can best approach improving access to quality addiction treatment.

First, the good news is that evidence-based treatments for addiction are starting to become more available. Cost-effective public and private specialty facilities have evolved using multi-dimensional, patient assessment criteria and the Levels of Care detailed in [The ASAM Criteria®](#). The Centers for Medicare and Medicaid Services (CMS) has [approved](#) over twenty Section 1115 waivers that waive the Institution for Mental Diseases (IMD) exclusion to allow federal dollars to pay for addiction treatment delivered in an IMD so long as certain state milestones are achieved. These milestones include a state's widespread use of [evidence-based](#), SUD-specific patient placement criteria and establishment of residential treatment provider qualifications that meet nationally recognized, SUD-specific, program standards, such as those

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found in *The ASAM Criteria*. Additionally, [Section 5052](#) of the SUPPORT for Patients and Communities Act makes explicit use of *The ASAM Criteria* to give states the option to pursue a state plan amendment that would allow a Medicaid program to cover addiction and related treatment services delivered in an IMD for up to 30 days of care during a 12-month period; provided, that certain conditions are met, including the provision of certain medications for opioid use disorder.

Second, there is also frustrating news for policymakers, patients, families, and treatment programs, alike. Recently, ASAM engaged in an examination of licensing, accreditation, and certification standards of addiction treatment facilities among a cross-section of states in connection with comments that ASAM submitted to the Medicaid and CHIP Payment and Access Commission (MACPAC) in connection with the Medicaid IMD Additional INFO Act. During the course of that cursory examination, ASAM staff found significant variations in standards for addiction treatment facilities in real-world practice. Additionally, ASAM has heard from its members that tremendous variation among states still exist in terms of prerequisites for licensure, certification, and accreditation for inpatient/residential treatment facilities, specifically. To add to this complexity, those terms are often defined differently by states and are used interchangeably, making it difficult to draw comparisons and complicating the functional delivery of care by treatment programs operating in multiple jurisdictions. Furthermore, the media and even well-meaning policymakers often conflate treatment and recovery support services. Treatment is provided by physicians and other credentialed clinicians and programs, and should follow best practices in the field. Recovery support services, like recovery housing or mutual support groups like Alcoholics Anonymous and SMART Recovery, are ancillary approaches to support a person in managing their disease. Conflating a residential treatment program with sober housing, or psychotherapy with support groups, causes further confusion to the public. We all must do a better job of clarifying the distinctive role that each of these interventions has in helping patients achieve and maintain remission from this chronic illness.

More specifically, in our limited search of seven states (California, Kansas, Oregon, Texas, Kentucky, New Hampshire, and Maine), we found wide variations in definitions and requirements.¹ For example, while all seven states appeared to require residential treatment facilities to obtain licensure from the state in order to conduct business operations, three states also appeared to require some form of certification, but definitions varied. The regulations and state codes in the other four states appear to use the terms interchangeably or the specific requirements were not readily available to ASAM staff during their limited search. In addition, some of these states appeared to require facilities to be accredited before obtaining certification, while information on the requirements of the other states were difficult to obtain from public information and calls to state regulators. While our findings do not speak to the specific standards of care or clinical guidelines that facilities in those states must follow to meet licensure, certification, or accreditation requirements, we note that in the absence of a federally mandated national standard, significant variation in the quality of oversight is likely.



ASAM, however, has developed nationally recognized, expert-derived standards for the treatment of addiction, and these standards can be used as a roadmap for how states can design licensure and certification requirements. *The ASAM Criteria* is the nation's most comprehensive and widely used set of standards to match patients to the appropriate Level of Care based on their disease severity. Indeed, *The ASAM Criteria* is used in some way, shape, or form by state regulators, clinicians, and payers across all care settings. As we have seen, however, while *The ASAM Criteria* has established a critical foundation for building a quality-driven national addiction treatment infrastructure, there is much more work to do to ensure states, payers, and treatment providers implement *The ASAM Criteria* comprehensively and effectively. ASAM is focused on developing the tools and resources necessary to help them do so.

Comprehensive and effective implementation of *The ASAM Criteria* requires three major components:

- (1) a standardized, multidimensional assessment to determine the severity of a patient's illness;
- (2) research-validated patient placement decision rules that use the results of the multidimensional assessment to recommend a Level of Care that meets that patient's treatment needs; and
- (3) nationally recognized, expert-derived Level of Care standards that define the care continuum and describe the service characteristics that define each Level of Care in it, so that patients matched with that Level of Care have the best chance of remission and recovery.

These three components, together, make up a solid foundation for a standardized, results-based addiction treatment system. However, most states and healthcare systems across the country do not fully implement these standards or provide access to the full continuum of care for addiction treatment. Implementation of these treatment system standards is not simple or easy. It will take ongoing, focused efforts to transform state addiction treatment systems to align with all components of *The ASAM Criteria* standards. To support effective adoption of these national standards, ASAM experts have developed a number of tools to support implementation with fidelity.

First, ASAM has developed clinical decision support software for determining the right level of care for a patient based on *The ASAM Criteria* ([ASAM CONTINUUM](#)). This program provides a standardized biopsychosocial assessment that addresses all six dimensions in *The ASAM Criteria* and implements decision rules for determining an individual patient's treatment needs and providing objective recommendations for the level of care appropriate for that patient.

Second, there is the ASAM Level of Care certification program, currently under development and to be delivered by CARF International (CARF). ASAM Level of Care certification will initially cover adult residential programs at [Levels 3.1, 3.5, and 3.7](#) of *The ASAM Criteria*. Certification covering adolescent programs, co-occurring enhanced programs, withdrawal



management, and programs at other Levels of Care—ranging from early intervention services (Level 0.5) to intensive, medically-managed inpatient services with round-the-clock physician staffing (Level 4)—may be developed in the future. Providers of residential substance use disorder services will submit applications directly to CARF seeking certification for Level 3.1, 3.5 and/or 3.7. CARF will conduct onsite surveys to evaluate the providers' satisfaction of ratable elements applicable to the applied-for Level(s) of Care and issue an independent certification decision.

To be issued certification, residential addiction treatment programs will need to demonstrate during an onsite survey the presence of ratable elements sufficient to satisfy the proprietary scoring methodology developed by ASAM experts, including but not limited to the presence of all “defining elements” – those certain ratable elements that are crucial to the operation of all residential treatment programs or are a hallmark of a particular Level of Care. Once certified, residential treatment programs will then need to address any deficiencies in a plan of action submitted to CARF and annually attest to continued satisfaction of the applicable ratable elements. To maintain uninterrupted certification beyond the three-year term of certification, residential treatment programs must timely apply for, and successfully complete, a recertification survey. This groundbreaking certification program presents a tremendous opportunity for state Medicaid programs and residential addiction treatment providers, including IMDs, to commit to nationally recognized standards for residential addiction treatment. This program will be the **first program of its kind** to assess and verify treatment programs' ability to deliver services consistent with the Levels of Care described in *The ASAM Criteria*. The Phase I pilot program has been completed (click [here](#) for the results), and Phase II is underway. ASAM currently anticipates a nationwide rollout of the ASAM Level of Care certification program in early 2020.

Third, ASAM is developing comprehensive educational and course offerings to train providers, payers, and other stakeholders on *The ASAM Criteria*. [The ASAM Criteria Course](#) will comprise of a comprehensive suite of competency-based learning activities that meet the learning needs of the multiple audiences making use of the Criteria and results in the appropriate use of the Criteria in practice.

Finally, given the billions of dollars that Congress is appropriating to combat our nation's addiction and overdose crisis, and the aforementioned lack of consistency, it is critical for policymakers to understand that *The ASAM Criteria* can be used as the basis for designing standardized state licensure and certification requirements for addiction treatment programs across the continuum of care. ASAM's Fair Use Guidelines allow states and other public entities to use *The ASAM Criteria* in legislation, regulations, or policies without permission or cost. In fact, certain provisions in the Comprehensive Addiction Resources Emergency (CARE) Act of 2019, including [Section 3435\(a\) of the CARE Act](#), address, head-on, these very treatment infrastructure issues. The CARE Act also acknowledges, however, this harsh reality -- that the field of addiction medicine has been severely underfunded over the past several decades and has lacked parity



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with the rest of medicine. It will take substantial, long-term investments to strengthen and train the addiction treatment workforce and better integrate federal grants with mainstream medicine, including treatment providers that accept Medicaid. This kind of fundamental standardization of our nation's addiction treatment ecosystem will not only put a medical floor under millions of patients and families battling addiction, but it will help ensure that public and private payers can better identify, and reimburse, only those addiction treatment programs that use evidence-based patient placement criteria and meet nationally recognized, expert-derived standards for addiction treatment. Indeed, some payers already voluntarily use, or are required to use by applicable state law, *The ASAM Criteria* as the basis for their medical necessity determinations.

In closing, ASAM experts welcome the opportunity to meet with you and your staffs and to be of service. We know that Congress can make important, bipartisan policy changes that strategically incentivize bold, systemic change designed to help save hundreds of thousands of lives, billions of taxpayer dollars, and an incalculable amount of human suffering. Thank you for your attention to this issue and the opportunity to provide input. If you have any questions or concerns, please contact Kelly Corredor, Vice President, Advocacy and Government Relations at kcorredor@asam.org or 301-547-4111.

Sincerely,

Paul H. Earley, MD, DFASAM
President, American Society of Addiction Medicine

ⁱ Selection methodology: The states noted in these comments were chosen based on geographic location, opioid overdose death rates, and the availability of publicly available information on certification/licensure/accreditation information. These states were chosen in an effort to represent a cross-section of states.