



ASAM American Society of
Addiction Medicine

OFFICERS

President

Paul H. Earley, MD, DFASAM

President-Elect

William F. Haning, III, MD, DFAPA, DFASAM

Vice President

Yngvild K. Olsen, MD, MPH, DFASAM

Secretary

Jeffrey Selzer, MD, DFASAM

Treasurer

Kenneth I. Freedman, MD, MS, MBA, FACP, DFASAM

Immediate Past President

Kelly J. Clark, MD, MBA, DFAPA, DFASAM

BOARD OF DIRECTORS

Directors-at-Large

Anthony Albanese, MD, DFASAM

Adam J. Gordon, MD, MPH, FACP, DFASAM

Brian Hurley, MD, MBA, DFASAM

Margaret Jarvis, MD, DFASAM

Marla D. Kushner, DO, FSAHM, FACP, DFASAM

Timothy Wiegand, MD, FACMT, FAACT, DFASAM

REGIONAL DIRECTORS

Anika, Alvanzo, MD, MS, FACP, DFASAM

Gavin Bart, MD, PhD, DFASAM

Gregory X. Boehm, MD, DFASAM

Murtuza Ghadiali, MD, FASAM

Frank James, MD, JD, FASAM

Miriam Komaromy, MD, FACP, DFASAM

A. Kenison Roy, III, MD, DLFAPA, DFASAM

Peter Selby, MBBS, CCFP, FCFP, MHSc, DFASAM

Scott Teitelbaum, MD, DFASAM

Melissa Weimer, DO, MCR, FASAM

EX-OFFICIO

Brent Boyett, DO, DMD, DFASA

Joseph M. Garbely, DO, DFASAM

Randolph P. Holmes, MD, FASAM

Ilse Levin, DO

Penny S. Mills, MBA, Executive Vice President/CEO

Aleksandra Zgierska, MD, PhD, DFASAM

FOUNDING PRESIDENT

Ruth Fox, MD

1895-1989

May 31, 2019

Medicaid and CHIP Payment and Access Commission (MACPAC)
1800 M Street NW
Suite 650 South
Washington, DC 20036

Re: Comments on the Medicaid IMD ADDITIONAL INFO ACT

Dear MACPAC Commissioners,

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 input on the topics set forth in the IMD ADDITIONAL INFO Act. Inpatient/residential addiction treatment facilities covered by Medicaid are essential components of our nation's addiction treatment care continuum. Notwithstanding the fact that Medicaid accounts for more than 21% of all spending on substance use disorder (SUD) services,ⁱ Medicaid's IMD exclusion often prohibits the use of Medicaid federal dollars for the treatment of psychiatric conditions or SUD in inpatient/residential treatment facilities with more than sixteen beds. This coverage limitation can prevent utilization of essential inpatient/residential treatment services for Medicaid beneficiaries, and patients may be turned away from essential care.

ASAM has long contended that the repeal of Medicaid's IMD exclusion is essential for ensuring access to medically necessary inpatient/residential services to treat addiction. At its inception, the IMD exclusion was well intended, but as evidence-based treatment for addiction has progressed and become available, the provision now often serves as a major obstacle for patients by denying coverage for treatment in larger inpatient/residential facilities. This prevents the treatment of patients using Medicaid dollars in cost-effective public or private specialty facilities that have evolved using the Levels of Care detailed in *The ASAM Criteria*®.

The Centers for Medicare and Medicaid Services (CMS) has attempted to mitigate some of these disparities with policies over time, including allowing for the waiver of certain federal requirements. Specifically, CMS



has approved twenty-one Section 1115 waivers that waive the IMD exclusion to allow federal dollars to pay for addiction treatment delivered in an IMD so long as certain 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, evidenced-based program standards. Additionally, provisions in the SUPPORT for Patients and Communities Act modify the IMD exclusion for pregnant and postpartum women and, effective later this year, give states the option to pursue a state plan amendment that would allow them 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.

Upon closer examination of licensing, accreditation, and certification standards among a cross-section of states, however, we still find significant variations in standards for these 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. To add to this complexity, those terms are often defined differently by states and are used interchangeably, making it difficult to draw comparisons.

For example, in our limited search of seven states (California, Kansas, Oregon, Texas, Kentucky, New Hampshire, and Maine), we found wide variations in definitions and requirements.ⁱⁱ 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 us during our limited search. In addition, some of these states appeared to require these 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 (including IMDs) to meet licensure, certification, or accreditation requirements, we note that in the absence of a federally mandated national standard, significant variation is likely.

Notwithstanding these findings, nationally recognized standards for the treatment of addiction in inpatient/residential settings do exist, and those standards can be used as a roadmap for how states can design licensure and certification requirements, specifically. *The ASAM Criteria* is the nation's most comprehensive and widely used set of standards to match patients to the best 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. However, as we have seen, 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 have the tools and resources necessary to implement it comprehensively and effectively, including with the respect to IMDs and their reimbursement under Medicaid.

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 these standards.

To support effective adoption of these national standards ASAM experts have further developed tools to support implementation with fidelity. First, there is the ASAM CONTINUUM[®], a computerized clinical decision support system that provides a computer-guided, standardized interview for assessing patients with SUD and co-occurring conditions. ASAM CONTINUUM aids clinicians in conducting a full biopsychosocial assessment that addresses all six dimensions of *The ASAM Criteria*. The decision engine uses research-validated questions (including tools such as the ASI (Addiction Severity Index), CIWA (Clinical Institute Withdrawal Assessment) and CINA (Clinical Institute Narcotic Assessment) instruments to generate a comprehensive patient report which includes a recommended Level of Care determination.

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

To be issued certification, residential addiction treatment programs will need to demonstrate during 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



ASAM American Society of
Addiction Medicine

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 ground-breaking certification program presents a tremendous opportunity for state Medicaid programs and residential addiction treatment providers, including IMDs, to commit to generally accepted standards of care 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*.

In conclusion, ASAM encourages MACPAC to discuss the importance of comprehensive and effective implementation of nationally recognized addiction treatment standards and to consider identifying ASAM's resources that can help Medicaid achieve that goal in its forthcoming report to Congress on IMDs.

Thank you for the opportunity to provide ASAM's input. If you have any questions or concerns, please contact Corey Barton, Senior Manager, Private Sector Relations at cbarton@asam.org or 301-547-4106.

Sincerely,

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

ⁱ Zur, J., Musumeci, M., Garfield, R. (2017, June 29). Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals. Henry J. Kaiser Family Foundation, retrieved: May 15, 2019: from <https://www.kff.org/medicaid/issue-brief/medicaids-role-in-financing-behavioral-health-services-for-low-income-individuals/>

ⁱⁱ 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.