American Society of Addiction Medicine

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

OFFICERS
President
R. Jeffrey Goldsmith, MD, DLFAPA, FASAM
President-Elect
Kelly Clark, MD, MBA, FASAM
Vice-President
Mark Kraus, MD, FASAM
Secretary
Margaret A.E. Jarvis, MD, FASAM
Treasurer
Brian Hurley, MD, MBA
Immediate Past President
Stuart Gitlow, MD, MPH, MBA, DFAPA

BOARD OF DIRECTORS
Directors-at-Large
Anthony P. Albanese, MD, FASAM
Paul H. Earley, MD, FASAM
Marc Galanter, MD, FASAM
Petros Levounis, MD, MA, FASAM
Yngvild K. Olsen, MD, MPH
John C. Tanner, DO, FASAM

Regional Directors
Region I
Jeffery Selzer, MD, FASAM
Region II
Jeffery Wilkins, MD, FASAM
Region III
Kenneth Freedman, MD, MS, MBA, FACP, FASAM
Region IV
Mark P. Schwartz, MD, FASAM
Region V
J. Ramsay Farah, MD, MPH, FAAP, FACMP, FASAM
Region VI
Gavin Bart, MD, PhD, FACP, FASAM
Region VII
Howard Wetsman, MD, FASAM
Region VIII
William F. Haning, III, MD, FASAM, DFAPA
Region IX
Ronald Lim, MD, FASAM
Region X
Terry Alley, MD, FASAM

Ex-Officio
Todd J. Kammerzelt, MD
Ilse R. Levin, DO
Surita Rao, MD
Scott Teitelbaum, MD, FASAM
Norman Wetterau, MD, FAAP, FASAM
Penny S. Mills, MBA, EVP/CEO

FOUNDING PRESIDENT
Ruth Fox, MD
1895-1989

July 27, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicaid and CHIP Managed Care Proposed Rule CMS-2390-P

Dear Acting Administrator Slavitt:

The American Society of Addiction Medicine (ASAM) is pleased to have the opportunity to comment on the Medicaid and CHIP Managed Care Proposed Rule. Established in 1954, ASAM represents more than 3,300 physicians and associated professionals dedicated to increasing access and improving the quality of addiction treatment, including treatment provided to Medicaid and CHIP Managed Care beneficiaries. As you know, addiction impacts nearly 12 percent of Medicaid beneficiaries aged 18 to 64, and Medicaid accounted for 21 percent of addiction treatment spending in 2009. As such, these new proposed regulations will have a significant impact on many Americans' ability to access high quality and affordable addiction treatment services. Below please find our comments and recommendations to strengthen further this proposed rule.

Standard Contract Provisions

Response to Requests for Prior Authorization (PA)

Firstly, we applaud proposed §438.3(s)(6), which would require a Managed Care Organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP) to provide a response to a request for prior authorization (PA) for a covered outpatient drug by telephone or other telecommunication device within 24 hours of the request and dispense a 72 hours supply of a covered outpatient drug in an emergency situation. This proposed regulation is much-needed, and we recommend strengthening it by including guidance to MCOs, PIHPs, and PAHPs regarding situations which would qualify for emergency medication supplies and how PA paperwork can be simplified. There are many patients whose outcome is fully dependent on the expediency with which medications such as buprenorphine are available. Given this, a definition of "emergency" should include anything that would represent a decrease in the risk of relapse and/or overdose.

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

A 2013 survey of ASAM members revealed that only a quarter (25.6%) of prior authorization requests for FDA-approved addiction medications receive a response on the same day, 30% receive a response the following day, nearly half (44.1%) aren't returned for at least two days, and 13.3% of requests went unanswered for more than five days. This delay in approval for evidence-based care not only diminishes the quality of care that patients are receiving, but in the case of a life-threatening disease like addiction, it can prove fatal.

Moreover, we recommend issuing guidance to MCOs, PIHPs, and PAHPs, either in the final rule or in FAQs, detailing situations that would qualify for emergency dispensing of covered outpatient drugs. Since even short delays in care for patients with severe addiction can be catastrophic, we recommend that emergency situations include, but not be limited to, the following: (1) PA approval pending, (2) first prescriptions, and (3) following detox or return to addiction treatment after relapse.

Additionally, we recommend issuing guidance to MCOs, PIHPs, and PAHPs regarding ways to simplify PA paperwork. In addition to revealing long delays in PA approval, our 2013 survey of ASAM members found that too often PA paperwork is a time-intensive and administratively burdensome process. More than half of respondents indicated that PA paperwork takes more than 15 minutes to complete. Such time-consuming paperwork requirements create real barriers to treatment and are poor uses of limited clinician and administrative staff time.

By requiring MCOs, PIHPs, and PAHPs to respond within 24 hours to a prior authorization request and dispense emergency supplies, this proposed rule would make significant improvements to approval processes that, while intended to ensure patients receive high-quality and cost-effective care, too often stand in the way of patients receiving such care.

Capitation Payment for Treatment in an Institution for Mental Disease (IMD)

Secondly, we applaud proposed §438.3(u), which would permit MCOs and PIHPs to receive a capitation payment from the state for an enrollee aged 21 to 64 who spends a portion of the month for which the capitation is made as a patient in an institution for mental disease (IMD) so long as the facility is a hospital providing evidence-based psychiatric or substance use disorder (SUD) inpatient care, or the facility is a sub-acute facility providing psychiatric or SUD crisis residential services and the stay in the IMD is for less than 15 days in that month.

While effective residential treatment for SUD almost always requires stays that exceed 15 days in length, we recognize that this allowance for 15 days of inpatient treatment at an IMD is a major departure from previous policy and is a step in the right direction. For too long, patients have faced barriers to accessing needed residential care due to the IMD exclusion, and we thank CMS for its efforts to remove those barriers by providing for certain circumstances in which plans may receive payment for enrollees who are patients in an IMD.

Other Contract Provision Recommendations

While not addressed by the proposed rule, we recommend CMS consider adding language to allow Medicaid and CHIP MCO and PAHP enrollees access to a growing model of care called "direct primary care." Under this model, physicians receive a monthly payment from the health plan (in this case, the MCO or PAHP), and the physician assumes responsibility for providing all primary care services, including care coordination, minor procedures, routine labs, and even dispensing of medications. While this model of care is available in some states under Medicaid,

others prohibit providers from charging a Medicaid patient “cash” (which is how the monthly payment to the physician, even if paid by the MCO or PAHP, is interpreted), effectively prohibiting this model of care. Since initial analyses of direct primary care suggest that it can both reduce costs (through reduced emergency department utilization, inpatient care, specialist visits and advanced radiology) and improve patient outcomes and experience, this model should be an available option for MCOs and PAHPs in all states.

Modernize Regulatory Standards

Network Adequacy

We applaud CMS for proposed §438.68, which would establish minimum standards in the area of network adequacy for specified provider types, and strongly recommend that CMS encourage states to include non-psychiatrist addiction certified physicians in their standards for behavioral health network adequacy. Because utilization rates within MCOs tend to be predominantly weighted toward mental health treatment over addiction treatment, MCOs’ provider panels tend to be predominantly composed of physicians specializing in psychiatry.

A number of MCOs restrict their provider panels to board-certified psychiatrists only, and do not accept specialist physicians providing addiction treatment. Furthermore, MCOs with provider panels accepting only psychiatrists tend to have treatment billing code structures designed to accommodate mental health treatment codes but not addiction treatment codes.

When MCOs deny non-psychiatrist addiction medicine physicians from joining their provider panels, access to quality and timely treatment is jeopardized, and member patients may be referred to in-network psychiatrists with insufficient training, experience, and interest in the treatment of substance use disorders. While tradition suggests that psychiatrists are the most qualified physician specialists to provide substance use disorder treatment, in fact, general psychiatrists may have had little didactic or clinical training on the topic in their residency training and minimal supervised experience treating such patient. Instead, physicians specializing in other areas, such as Internal Medicine, Family Practice, Obstetrics-Gynecology, Emergency Medicine and Pediatrics, may have the same or more training and treatment experience as psychiatrists.

Board certified addiction medicine physicians, whether psychiatrists or non-psychiatrists, are the most trained and experienced specialty group to provide quality treatment for patients presenting with substance use disorders. Addiction medicine physicians undergo a rigorous board certification process and spend at least fifty-percent of their clinical practice treating patients with substance use disorders. They include psychiatrists and non-psychiatrists who are certified by the American Board of Addiction Medicine (ABAM), the American Society of Addiction Medicine (ASAM), or the American Osteopathic Association (AOA). Additionally, the American Board of Psychiatry and Neurology (ABPN) and the American Osteopathic Board of Neurology and Psychiatry (AOBNP) certify psychiatrists in the subspecialty of addiction psychiatry.

As such, we recommend CMS instruct MCOs, PIHPs and PAHPs to allow non-psychiatrist ABAM-board certified and ASAM-certified addiction medicine physicians to be part of their provider networks and treat member patients diagnosed with substance use disorders. Furthermore, psychiatrists who are ABAM-board certified or ASAM-certified and regularly treat patients diagnosed with substance use disorders but are not ABPN- or AOBNP-board certified in psychiatry should be included in these provider networks as well.

Finally, we also applaud CMS's proposal to promote transparency and public input for these managed care network adequacy standards by requiring states to publish their network adequacy standards on the Medicaid managed care website.

Quality of Care

We commend CMS for proposing to require states to establish comprehensive quality strategies for the Medicaid and CHIP programs, regardless of how services are provided to beneficiaries. Ensuring the quality of treatment services provided to patients with addiction by addiction physician specialists is one of ASAM's top priorities. As such, we have developed a set of nine Performance Measures for the Addiction Specialist Physician, which are intended to evaluate physician performance against the Standards of Care for the Addiction Specialist Physician.

There are three performance measures (which are all process measures) currently undergoing specification and testing:

1) Percentage of patients who are prescribed medications for alcohol use disorders;
2) Percentage of patients who are prescribed medications for opioid use disorders; and
3) Withdrawal management follow-up, which assesses the extent to which patients initiate treatment within 7 days after receiving withdrawal management services.

Once these measures are fully specified and tested, we recommend their inclusion in all Medicaid performance measure sets, as they will help evaluate and ensure Medicaid beneficiaries are receiving evidence-based addiction treatment services.

Thank you again for the opportunity to provide comments on these important proposed regulations. We look forward to continuing to work with CMS and MCOs to improve the quality and accessibility of treatment for addiction.

Sincerely,

R. Jeffrey Goldsmith, MD, DLFAPA, FASAM
President, American Society of Addiction Medicine