American Society of Addiction Medicine

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Treat Addiction ● Save Lives

January 31, 2012

Steve Larsen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

Dear Mr. Larsen:

The American Society of Addiction Medicine (ASAM) is pleased to have the opportunity to comment on the Essential Health Benefits (EHB) Bulletin, which the Center for Consumer Information and Insurance Oversight (CCIIO) published on December 16, 2011 ("the Bulletin").

Established in 1954, ASAM has nearly 3,000 members and chapters that cover 42 states. Our members specialize in the treatment of addiction and practice in a wide range of primary care and specialty care settings. As such, we feel uniquely qualified to comment on the provisions of this proposed rule that have the potential to increase patient access to mental health and substance use disorder treatment.

ASAM supports the goals of health care reform to ensure that all Americans, particularly the marginalized and vulnerable, have access to high quality, evidence-based, affordable health care. This includes care for the treatment of addiction and other health conditions related to the use of alcohol, nicotine and other drugs, and illicit use of prescription medications. At the most fundamental level, access to good health care relies upon access to qualified health care professionals. ASAM would like to comment, specifically, on the sections of this proposed rule that have a direct impact on a patient's access to an appropriate addiction and mental health benefit package that is comparable in scope to the essential health benefits package for other medical/surgical conditions they may have access to through their privately-sponsored or publicly-sponsored health plan.

A long history of insurance discrimination against those with substance use and mental health disorders (SUD/MH) has prevented many individuals from receiving the clinically appropriate care needed to get and stay well. There is also an unacceptably large treatment gap for SUD/MH. Nearly one-third of adults and one-fifth of children have a diagnosable substance use or mental health problem[1], however in 2009, only 4.3 million of the 23.5 million Americans needing treatment for an illicit drug or alcohol problem received it.[2]

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h financing in the United States: A primer. Kaiser Commission on Medicaid and the

ntal Health Services Administration. (2010). *Results from the 2009 National Survey on me I. Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A. 10-4856). Rockville, MD.

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The Affordable Care Act (ACA) holds tremendous promise for significantly reducing SUD/MH treatment gaps, but without a robust EHB and a minimum state SUD benefit requirement to ensure access to medically necessary SUD and MH care this potential will go largely unfulfilled

KEY PROVISIONS IN THE BULLETIN

- **Application of Parity In and Outside of Exchanges is Critical.** ASAM members appreciate the Bulletin's explicit recognition of the ACA's requirement that the EHB include addiction and mental health treatment services, and in a manner consistent with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA).

  As noted in the Bulletin, MHPAEA applies to covered addiction and mental health benefits but is not a mandate and, prior to the ACA, small group and individual plans were exempt from the law's requirements. However, by requiring coverage of addiction and mental health benefits as one of the EHB categories and extending MHPAEA to small group and individual plans, Congress mandated that all public and private plans subject to the EHB, inside and outside of the insurance Exchanges, be required to offer addiction and mental health benefits at parity with the medical/surgical benefits offered by the plan. ASAM members agree that application of parity outside of the exchanges is critical to create a level playing field in the insurance marketplace and to avoid adverse selection in the exchanges. We thank the Department for its clear recognition of these critically important ACA requirements.

- **Allowing States to require compliance with State mandated benefits**. 40 states have some form of addiction and mental health parity or mandated benefit laws, some of which provide stronger consumer protections than the federal law. The Department should work closely with all States to ensure existing state mandates are upheld to the greatest extent possible.

- **Reemphasizing that each of the ten EHB categories is mandated** and providing guidance to States about how to supplement coverage if a category is not covered in the particular benchmark plan option chosen by the State.

- **Limiting benefit design flexibility and ensuring plans provide a certain level of benefits**. As you know, both the Children's Health Insurance Program (CHIP) flexibility standards and the application of the MHPAEA preclude downward actuarial adjustments to addiction and mental health benefits. As discussed in more detail below, we also ask the Department to include language in a further EHB guidance document to explicitly affirm this prohibition.

PROPOSED MODIFICATIONS TO THE BULLETIN

ASAM members respectfully offer the following 6 modifications to the Department in response to the EHB Bulletin. Our consideration of these issues is informed by our experiences with health insurance coverage for SUD/MH, which has historically been provided at extremely low levels, if at all. The following is a summary of our recommendations for final EHB guidance for your consideration. We urge the Department to:

1. Develop a detailed, comprehensive essential health benefits (EHB) package that would serve as a "federal floor," similar to the approach used in the Health Insurance Portability and Accountability Act (HIPPA). We continue to believe that a minimum federal EHB that States could go beyond to meet their specific needs is the preferred approach, and ask the Department to develop a minimum federal benefit package.

   However, if the Department continues to allow States to define their EHBs absent a federal floor, we ask the Department to ensure that each of the ten categories of benefits is consistent with the CHIP benchmark plans (Blue Cross Blue Shield [BCBS] Federal Employees Health Benefit Program [FEHBP] plan, a plan that is offered and generally available to State employees, and the largest non-Medicaid HMO) in the State and change the default plan from a small employer plan to the BCBS FEHBP plan or another comprehensive benefits package defined by HHS.

2. Implement a MHPAEA final rule, aggressively enforce MHPAEA on the federal level and provide specific guidance on MHPAEA implementation and enforcement to States to ensure meaningful protection.

3. Ensure quality, evidence based benefits within the EHB by:

    a. Requiring that each of the ten EHB categories be medically appropriate and evidence based in the benchmark plan, and if a category is not medically appropriate in the benchmark plan, the Department should require the State to supplement the category using a benchmark option that does provide high-quality, evidence based benefits in that category;

    b. Including language in the final EHB guidance and the forthcoming actuarial value guidance clearly stating that both the MHPAEA and CHIP flexibility standards preclude downward actuarial adjustment to SUD and MH benefits;

    c. Developing a federal definition of medical necessity;

    d. Ensuring robust prescription drug coverage, including medication-assisted addiction treatment; and

    e. Requiring use by plans in and outside of the exchange of the ASAM Patient Placement Criteria for individuals with substance use disorders. These criteria for placement into defined levels of care (intensities of service) for persons with substance use disorders (SUDs) are currently used in 30 states.

4. Annually review and update the EHB in all States and assess whether plan enrollees are being well served. Evaluation of the performance of the health insurance marketplace after implementation of the ACA and its various administrative rules is essential—consumers and providers of care should have data on what is working and what is not with respect to access, affordability, and utilization, as well as adherence to rules, especially regarding utilization management. An EHB final rule should require states to take appropriate action when plans fail to provide a comprehensive EHB package consistent with the requirements of the ACA. The Department should also provide annual guidance to States requiring that they update their EHBs to reflect changes in medical evidence, best practices and scientific advancement.

5. HHS should provide benefit data from the specific plans that would be eligible at this point in time to serve as benchmarks in a state, and do so as soon as possible.

6. Prior to 2014, there should be a strong consumer and family education campaign to ensure SUD and MH service consumers understand how to access new coverage benefits and can identify potential violations of their EHB rights.

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1. Develop a detailed, comprehensive essential health benefits package that would serve as a "federal floor," similar to the approach used in the Health Insurance Portability and Accountability Act (HIPPA). We continue to believe that a minimum federal EHB that States could go beyond to meet their specific needs is the preferred approach, and ask the Department to develop a minimum federal benefit package.

However, if the Department continues to allow States to define their EHBs absent a federal floor, we ask the Department to ensure that each of the ten categories of benefits is consistent with one of the 3 CHIP benchmark plans (Blue Cross Blue Shield (BCBS) Federal Employees Health Benefit Program (FEHBP) plan, a plan that is offered and generally available to State employees, and the largest non-Medicaid HMO) in the State and change the default plan from a small employer plan to the BCBS FEHBP plan or another comprehensive benefits package defined by HHS.

Develop a Federal Floor for the Essential Health Benefit
When Congress passed the ACA and included EHB requirements they intended to create a uniform minimum benefit standard that would apply to all States, guarantee small group and individual market health plan enrollees a basic level of protection, and ensure that federal subsidy dollars would be well spent. While we understand the Department's intent to give States a significant amount of flexibility to design their benefits packages, we continue to believe that a national standard is needed that will guarantee strong and specific benefit protections to all covered enrollees, especially for individuals with addictive disorders because of long-standing insurance discrimination that permitted plans to deny access to these benefits.

We believe that an approach to EHBs that draws on the success of proven federal frameworks that promote State flexibility within the context of a defined federal standard, such as HIPAA and traditional Medicaid models, would offer significant benefits to consumers by establishing a minimum floor for essential health benefits that is uniform across the states. Under such a model, states would be permitted to identify essential health benefits above the federal floor, preserving state autonomy and flexibility to adapt to local health care needs. States differ widely on their support for the ACA and their commitment to effectively implement and enforce the law. Therefore, in the absence of a federal floor on benefits, we believe there is a significant risk that coverage for addictive disorders and other commonly excluded benefits, such as habilitative care, will be inadequate in many States.

In the absence of a federal floor, limit State flexibility to reduce any of the 10 EHB categories
We encourage the Department to define and clearly indicate limits on State flexibility to reduce any of the ten EHB categories—and to clearly require States to comply with the additional prohibitions under MHPAEA against limiting the SUD/MH benefit category—and to enforce these limits. HHS should annually review State benchmark proposals for comprehensiveness of each of the ten EHB categories and require States to supplement categories that fall short.

In the case that a State chooses to benchmark to a plan that does not provide full and specific details about some or all of the benefits it offers, the Department should require States to develop specific benefit details, and work with them to do so. As a result, all States should have comprehensive and detailed State benefits packages that ensure coverage of all medically necessary services across the continuum of care in each of the categories. In addition to working closely with States, we ask the Department to include in the final EHB rule strong enforcement mechanisms and federal oversight to ensure that all health plans subject to the EHB will be in compliance with the essential health benefits and SUD/MH parity requirements of the law.

Benchmark choices should reflect the benchmark flexibility allowed under the CHIP program and for certain Medicaid populations
The Bulletin notes that the approach put forth by the Department is based on the approach taken by CHIP and allowed for certain Medicaid populations. However, the Bulletin proposes to allow States to benchmark their EHBs to additional options beyond the flexibility allowed by CHIP and Medicaid; in particular, it proposes to allow States to benchmark to one of the three largest small group insurance plans in the State. This added flexibility may lead to a "race to the bottom" in terms of benefit packages.

We urge the Department to limit States' flexibility to benchmark their EHB packages to only include large group plans. We believe this would be best met by better aligning State EHB benchmark flexibility with the benchmarking options allowed by CHIP and Medicaid, in §2103 and §1937 of the Social Security Act, respectively, and allow States to choose EHB benchmarks that are at least equivalent to one of the following:

- The standard Blue Cross Blue Shield preferred provider option in the FEHBP;
- A health plan that is offered and generally available to State employees in the State involved; or
- The largest non-Medicaid HMO operating in the State.

More closely aligning EHB benchmark flexibility to the flexibility allowed by CHIP and for certain Medicaid populations would serve to better protect enrollees by generally providing better coverage, and would limit benefit variation across States.

The default plan should not be a small group plan

We are concerned that small group plans may not offer adequate benefit packages, particularly related to SUD and MH. As noted in the Bulletin, during the HHS listening sessions following the release of the IOM report on EHB, a number of consumer groups expressed concern that small group plans may not represent the typical employer plan envisioned by the statute. ASAM, as part of the Coalition for Whole Health, was among the groups that expressed this concern. The Bulletin goes on to state that small group plans and other potential benchmark options do not differ significantly in the range of services they cover. We encourage the release of this data to allow for independent analysis of all plans. Absent the data we cannot be certain that SUD/MH benefits are adequately covered in these plans; indeed, the Bulletin acknowledges that for SUD/MH, "coverage in the small group market often has limits."

While the application of the requirements of MHPAEA to all EHB coverage is important to ensure adequate coverage for SUD/MH, we continue to have serious concerns that coverage based on the benefits offered in the small group market may be insufficient. While the ACA's parity requirements should—and legally must—mitigate this problem for SUD/MH services, we remain concerned that basing the EHB on a small employer plan would likely result in weaker SUD/MH coverage, especially in the short term, since small employer plans have been exempt from the federal parity laws. We believe the benefits offered today in the large group market better reflect the "typical" coverage that Congress intended to be available in the small group and individual markets beginning in 2014.

Given the limitations of the small group market, we have serious concerns that the Bulletin is proposing to use a small employer plan as the default benchmark plan for States that do not exercise the option to select a benchmark health plan. The largest small employer plan in a State may well be the weakest and most variable of the ten options. Instead, we urge the Department to adopt the standard Blue Cross Blue Shield FEHBP plan or an HHS defined comprehensive essential health benefits package as the default benchmark plan, to provide a comprehensive federal standard in at least a number of States.

Enforcement of Strong EHB consumer protections

We recognize that the Department intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback. Assuming the Department continues to allow States to choose among benchmark options absent a federal benefits floor at least through 2016, we strongly urge you to exercise an assertive oversight role to ensure appropriate protections for plan enrollees.

We also urge the Department to aggressively enforce the strong consumer protections applied to the EHB in §1302(b)(4)(A-D) of the ACA, which require the Secretary to:

- Ensure that the essential health benefits reflect an appropriate balance within and among the categories so that benefits are not unduly weighted toward any category;
- Not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;
- Take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;
- Ensure that health benefits established as essential not be subject to denial on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life.

The final EHB regulations should integrate these protections into the Department's criteria for approving State benchmark proposals.

Again, absent a strong federal benefits floor, we ask the Department to include further regulatory guidance that provides strong oversight of States and all necessary technical assistance to ensure comprehensive coverage of each of the ten categories in the EHB.

2. Strong MHPAEA regulatory guidance and enforcement on both the federal and State levels is needed to ensure meaningful access to SUD/MH EHB benefit

We believe that the ACA and the MHPAEA hold tremendous promise to reduce and eliminate the historical insurance discrimination against individuals with SUD/MH. ASAM members applaud the Department for including provisions in the Bulletin clarifying that that the ACA requires the EHB to include SUD and MH benefits in a manner consistent with the requirements of MHPAEA.

With the passage of the MHPAEA in 2008, Congress sought to end the long history of insurance discrimination against those with SUD/MH that has prevented so many individuals from receiving the clinically appropriate type, level, and amount of care they need to get and stay well. However, there are still significant problems in implementation and enforcement of the federal parity law which require special consideration from the Department as it works to define and implement the EHB. Lack of clarity in the regulations in four key areas has prevented equitable access to SUD/MH care. These include:

- Disclosure of medical criteria used to make medical necessity determinations so providers and patients have the information needed to do a parity compliance test
- Standards and safe harbors for implementing parity in medical management
- Scope of services
- Medicaid managed care parity

Without additional regulatory guidance in these areas as well as enforcement of existing MHPAEA regulations and parity provisions included in the EHB Bulletin, the parity law will not provide the critically needed federal protection from health insurance discrimination for the millions of Americans with substance use disorders and mental illness that Congress intended. Final MHPAEA regulations implementing parity in Medicaid managed care plans and clarifying what plans' scopes of services are, and what their non-quantitative treatment limitation obligations are, must be fully implemented expeditiously. We look forward to working with you to ensure that these measures are well understood and widely implemented so that the parity provisions in the Bulletin achieve the aim of increasing access to SUD/MH care.

Though the MHPAEA regulations went into effect for all plans on January 1, 2011, providers and consumers are still experiencing discriminatory treatment access. For example, some plans are claiming to be parity compliant by providing sparse or single levels of inpatient hospital services, sparse or very limited levels and types of outpatient services, and/or applying disproportionate restrictions on SUD and MH services and prescription drugs such as "fail first" policies. These cost-containment techniques are often applied more stringently with respect to SUD/MH benefits than to other medical benefits. These and other barriers to access are hurting individuals today and also threaten to jeopardize access to SUD/MH benefits for enrollees in plans subject to the EHB beginning in 2014.

We ask the Department to work with States and its federal partners to ensure strong enforcement of the MHPAEA that is currently lacking. The EHB Bulletin and subsequent guidance and regulations should ensure that all EHB-subject plans must not apply any financial requirement or treatment limitation, either quantitative or nonquantitative, to SUD/MH benefits in any classification, that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. These parity requirements must apply to treatment limitations on the scope and range of services and settings covered within any benefit classification, regardless of any flexibility given to States to define their EHB.

Some states still assert that enforcing parity is solely a federal responsibility. We urge the Department to include language in the final EHB guidance that clearly indicates to States that they are responsible for

implementing and enforcing MHPAEA and the ACA's parity requirement in their State. HHS should also clarify that HHS assumes the responsibility for MHPAEA compliance in the event of a state's failure to implement the law.

3. **The Department should require medically appropriate coverage of each EHB category by (a) requiring States to supplement missing or inadequately covered categories using other benchmark options to provide evidence based benefits in that category; (b) clearly stating that EHB benefit flexibility standards preclude downward actuarial adjustment of SUD and MH benefits; (c) developing a federal definition of medical necessity; and (d) ensuring robust prescription drug coverage, including robust coverage for all FDA-approved SUD/MH medications.**

Require essential benefits in each of the ten EHB categories

As stated above, we strongly support the acknowledgment in the Bulletin that all issuers subject to the EHB standard must cover each of the ten benefit categories, regardless of the benchmarking flexibility given to States. This requirement is consistent with §1302 of the ACA. ASAM is concerned, however that the Bulletin seems to suggest that providing any benefits in a category would meet the EHB standard.

In the event that a State chooses a benchmark plan that is "missing categories," the Bulletin proposes to require the State to "supplement the missing categories using the benefits from any other benchmark option." The Bulletin also provides a similar process for determining benefits in a State with a default benchmark that is "missing categories." An example provided explains that "in a State where the default benchmark is in place but that default plan did not offer prescription drug benefits, the benchmark would be supplemented using the prescription drug benefits offered in the largest small group benchmark plan option with coverage for prescription drugs." We are concerned that requiring only the provision of any benefit in a category to meet EHB compliance would be far too weak a threshold, violating §1302(b)(4) of the ACA's instruction to the Secretary to ensure that the EHB reflects "an appropriate balance among the categories."

We strongly urge the Department to require that the *benefits* in each category be medically appropriate and comprehensive. Widely accepted patient placement criteria should be used to determine medical appropriateness. For example, the *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders-- Second Edition, Revised* (PPC-2R) of the American Society of Addiction Medicine (ASAM) is widely used tool by which practical and clinical determination of substance use levels of care can be measured.[3]

If the benchmark does not include all medically appropriate benefits in a benefit category, the Department should require that the benefits in that category be supplemented with the benefits in other benchmark options to make it comprehensive.

Provide clear guidance that the MHPAEA and benefit flexibility standards preclude downward actuarial adjustment of MH and SUD benefits

The Bulletin makes clear that the Department will permit actuarial adjustment and allow plans to offer benefits that are "substantially equal" using the same actuarial equivalency standard that applies to plans under CHIP. As you know, CHIP reauthorization amended §2103 of the Social Security Act to ensure compliance with the requirements of the MHPAEA in the case of a State child health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, and protected MH and SUD services from actuarial adjustment. Similarly, the ACA amended §1937 to extend the MHPAEA requirements to Medicaid benchmark plans and protect SUD/MH services from actuarial adjustment in Medicaid benchmark or benchmark equivalent benefits packages. We ask that the Department include language in the final EHB guidance, as well as the upcoming actuarial value

[3] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Griffith JH, eds. *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, 2nd edition, revised*. Chevy Chase, MD: American Society of Addiction Medicine; 2001.

guidance, explicitly stating the MHPAEA and CHIP flexibility standards both preclude downward actuarial adjustment to MH and SUD benefits in the EHB.

Provide clear guidance on substitutions across and within categories
The Bulletin also explains that the Department is considering permitting substitutions across benefit categories as well as within them. ASAM members are concerned that this flexibility could weaken coverage and reduce or eliminate important benefits, dilute categories, and undermine the EHB as a whole. We urge the Department to prohibit substitution of benefits across and within categories and only allow flexibility to improve and expand benefits. For the purpose of the SUD/MH benefit category, further regulatory guidance should reflect that the application of the MHPAEA and CHIP flexibility standards to the EHB would also similarly protect it from across category benefit substitution.

Define federal standards for medical necessity
While the Bulletin does not address medical necessity standards within the context of EHBs, the degree to which Americans enjoy full access to covered services within the ten EHB categories will depend, to a large degree, on the medical necessity and other medical management standards that plans use to determine whether a service is covered.

Few regulations address the definition of medical necessity: there is no federal definition, and only about one-third of states have any regulatory standards for medical necessity. Consequently, the definition of "medical necessity" is most commonly found in individual insurance contracts that are defined by the insurer and often not available to physicians and patients. As a result, the standard of medical necessity is most often controlled by the insurer, not the treating physician. Even when a clinical recommendation is consistent with professional clinical guidelines, the insurer may reject a proscribed treatment if it is inconsistent with other definitional elements such as relative cost, efficiency and effectiveness.

ASAM's recommendations for a federally defined medical necessity standard are consistent with the findings of the Institute of Medicine's recent report, *Essential Health Benefits: Balancing Coverage and Cost,* released October 7, 2011, which discusses a framework for HHS to address medical necessity within the essential health benefit, stating: "The committee believes that the concepts of individualizing care, ensuring value, and having medical necessity decisions strongly rooted in evidence should be reemphasized in any guidance on medical necessity. Inflexibility in the application of medical necessity, clinical policies, medical management, and limits without consideration of the circumstances of an individual case is undesirable and potentially discriminatory."

Enforce requirement that plans disclose medical criteria
Even with an unambiguous requirement under the parity law for plans to provide medical necessity criteria, plans have been slow and resistant to providing the criteria, especially criteria used to make medical benefit determinations. Without this data, a complete parity compliance test is difficult. The medical necessity definitions utilized by insurers today have an especially strong impact for SUD/MH, where treatments often vary widely in cost. For example, a course of treatment that emphasizes prescribed medications and brief therapy may have radically different costs from one that is long-term. We therefore strongly encourage the Department to define federal standards for medical necessity under the EHB and reinforce that both the medical and behavioral medical necessity criteria be made available to providers and patients. Given that medical necessity definitions commonly used by insurers today often impede access to appropriate SUD/MH treatment, federal medical necessity standards for this category of the EHB are critically important.

Ensure appropriate prescription drug coverage, including coverage of all FDA-approved SUD medications
The Bulletin indicates that the Department is proposing a standard similar to the flexibility permitted in Medicare Part D for prescription drug benefits. We note that Medicare Part D requires prescription drug plans to cover "all or substantially all" medications in six categories – namely, antidepressants, antipsychotics, anticonvulsants, antineoplastics, immunosuppressants and antiretrovirals. The Bulletin does not appear to envision a similar requirement, noting instead, "if a benchmark plan offers a drug in a

certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary."

Extending plan flexibility beyond the Part D standard for these categories of medications will endanger SUD/MH patients – and other patients – who may only respond to specific drugs. We urge the Department to clarify that all plans must offer "all or substantially all" medications in these six categories, regardless of the prescription drug coverage in the benchmark plan.

We strongly recommend CMS ensure individuals have access to the full continuum of FDA-approved addiction pharmacotherapies at parity. Like other chronic diseases such as diabetes and hypertension, medical management of addiction may include medications (agonist and antagonist) that are taken for varying periods, including prolonged periods. The National Quality Forum (NQF) has issued guidelines recommending the combination of medications and psychosocial support as part of an integrated SUD treatment program.[4] When medications and psychosocial support are used for addiction treatment they:

- Improve the patient's overall survival
- Improve patient retention in treatment
- Decrease heroin, alcohol and other drug use
- Decrease the transmission of HIV
- Decrease criminal activity
- Increase social functioning including employment and housing[5]
- Improve birth outcomes[6]

ASAM strongly recommends that all FDA-approved medications should be covered for SUDs and matched to the assessed individuals' clinical need and personal preference.

Require use by plans in and outside of the exchange of the ASAM Patient Placement Criteria for individuals with substance use disorders

Widely accepted patient placement criteria should be incorporated to ensure individuals receive the optimal level of SUD/MH care for the amount of time that is deemed medically necessary. The *Patient Placement Criteria for the Treatment of Psychoactive Substance Use Disorders-- Second Edition, Revised* (PPC-2R) of the American Society of Addiction Medicine (ASAM) is a widely used tool in 30 states by which practical and clinical determination of substance use levels of care can be measured.[7] Plans must be required to use patient placement criteria for the placement of patients in the appropriate level of care. The effects of SUD/MH treatment are optimized when individual patients are matched with appropriate levels of care.[8]

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[4] National Quality Forum Report, National Standards for the Treatment of Substance Use Conditions, 2007.

[5] **Alford DP, LaBelle C, Richardson JM,** O'Connell JJ, Hohl CA**, Cheng DM, Samet JH.** Treating homeless opioid dependent patients with buprenorphine in an office-based setting**.** J Gen Intern Med. 2007; 22:171-176**.**

[6] Strain EC, Stitzer ML. Methadone Treatment for Opioid Dependence. 1999.

[7] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Griffith JH, eds. *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, 2nd edition, revised*. Chevy Chase, MD: American Society of Addiction Medicine; 2001.

[8] Sheedy C. K., and Whitter M. (2009). Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research? HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

4. The EHBs should be reviewed and updated annually in all States to ensure that plan enrollees are being well served and that EHBs reflect the latest medical and scientific advancements.

The Bulletin asks for input on how the Secretary should meet the requirement to periodically review and update the EHB. We believe that HHS should annually review and update the EHB in each State to ensure that the EHB is effectively meeting the needs of plan enrollees, and take appropriate action if States or plans fail to provide a comprehensive EHB package consistent with the requirements of the ACA. We also believe that the Government Accountability Office and other independent federal agencies should bi-annually review EHB compliance and effectiveness.

HHS should provide annual guidance to States requiring that they update their EHBs to reflect changes in medical evidence and scientific advancement. As with many other diseases, there is currently much scientific progress being made in the prevention and treatment of MH and SUD. The National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA), and other public and private sector institutions are conducting cutting edge research on SUD and MH, and new evidence, research, and medical innovations will need to be adopted by the healthcare system as they are developed and proven.

Finally, HHS must ensure that States maintain a quality, modern EHB that reflects the latest innovations and provides essential benefits regardless of whether the State's benchmark plan updates or reduces its benefits package. Plans should not be able to take advantage of the benchmark flexibility to make harmful coverage determinations that could impact all enrollees in a State's qualified health plans.

5. HHS should release the survey of State benchmark plans

It is extremely important that HHS identifies and releases publicly the benefit survey data HHS conducted on each benchmark option for each State, so that the Department, States, consumers, providers, and advocates can effectively work together with our State chapters to identify options and ensure that the EHB in each State will effectively meet the needs of impacted beneficiaries. ASAM recently joined the Coalition for Whole Health in sending a letter to HHS encouraging the release of the plan data, and we strongly urge HHS to release this information as soon as possible.

6. Consumers and providers should have regular opportunities to participate and influence the EHB determination process and its outcomes. The Department should also implement a strong consumer and family education campaign to ensure consumers understand their coverage and rights.

Implement a strong consumer and family education campaign about EHB coverage and rights
The Department should also work with States to ensure a strong consumer, family and provider education component related to EHB implementation and enforcement. Consumers and their families should receive basic information on the benefits available, know what would constitute potential violations of their EHB rights, and be able to take appropriate action to correct violations of their rights and to appeal plan decisions. We urge the Department to develop an appeals process at the federal level that can provide recourse to individuals who have been failed by State review. To ensure that the EHB includes essential benefits that are critical to enrollees, there must be an appeals review process that is accessible so that enrollees can realize the benefits to which they are entitled. A quick and strong benefit appeals program at the federal level will be especially important to individuals in need of MH and SUD treatment. Individuals with addiction and mental health conditions have the lowest success rate of appeals of any medical condition. Furthermore, we urge the Secretary to review data from this appeals process to uncover patterns of benefit denial which may suggest common access problems faced by enrollees. The Secretary can use this data to update essential benefit package standards.

HHS and States should also work closely with community organizations and with health care providers to ensure patients are able to access the care they need. The Department should solicit input from the SUD/MH community about how the federal parity law and the ACA have changed access to MH and SUD

treatments and services. Lessons learned from parity law implementation should help to inform the discussion about how to update SUD/MH benefits in the EHB.

Again, ASAM thanks CMS for the opportunity to submit comments regarding this important issue. We look forward to a continued collaboration with the Centers for Medicare and Medicaid Services on advances in and increased access to alcohol and drug addiction treatment.

Sincerely,

Stuart Gitlow, MD, MBA, MPH, FAPA

Acting President, American Society of Addiction Medicine