From: Mark Parrino [mailto:mark.parrino@aatod.org]
Sent: Tuesday, May 26, 2009 4:51 PM
To: EBSA, E-OHPSCA - EBSA
Subject: Request for Information re: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
Importance: High

Please find attached AATOD's letter regarding the above referenced subject. Please confirm receipt. Thank you.

Mark

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Expanding Access to Quality Addiction Treatment Services

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May 26, 2009

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N–5653
U.S. Department of Labor
200 Constitution Avenue, NW.
Washington, DC 20210

Attention: MHPAEA Comments

Re: **45 CFR Parts 144 and 146**
[CMS–4140–NC]
RIN 0938–AP65
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

To Whom It May Concern:

I am writing in reference to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

The American Association for the Treatment of Opioid Dependence (AATOD) represents more than 850 opioid treatment programs (OTPs), which are certified/registered by the Substance Abuse and Mental Health Services Administration /Center for Substance Abuse Treatment (SAMHSA/CSAT). The nation's OTPs treat more than 260,000 patients for chronic opioid dependence/addiction on any given day.

At the outset, AATOD supported the passage of MHPAEA, especially with the addition of substance use disorder benefits. We believe that this legislation will improve access to substance abuse treatment throughout the United States and also improve retention in treatment once the patient has made the critical decision to seek treatment for their substance use disorder.

Our Association's remarks are limited to how the MHPAEA will incorporate the use of medication-assisted treatment (methadone/buprenorphine) for the treatment of chronic opioid dependence/addiction. It is understood that the MHPAEA requires plans or coverage to ensure that "…the treatment limitations, including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment, applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan."

It is critically important that the implementation of the provisions of MHPAEA incorporate what long term research and evidence based clinical practice have found with regard to the use of medication-assisted treatment for chronic opioid dependence/addiction. The hallmark parity coverage should allow the patient to continue to receive medication-assisted treatment as long as the patient continues to benefit from such ongoing medical care. The SAMHSA/CSAT Treatment Improvement Protocol (TIP No.43), " Medication-Assisted Treatment for Opioid

Addiction in Opioid Treatment Programs, references several key research findings in this regard in Chapter 8, "Approaches to Providing Comprehensive Care and Maximizing Patient Retention."

> "Studies of patients who left medication-assisted treatment (MAT) prematurely have determined that length of retention was the most important indicator of treatment outcomes. Patients who stayed in treatment a year or longer abused substances less and were more likely to engage in constructive activities and avoid criminal involvement than those who left treatment earlier."

This chapter also referenced research conducted by Drs. Magura and Rosenblum.

> "Setting maximum lengths of stay for all patients or emphasizing low-dose medication goals can discourage retention and produce poor outcomes."

The point is not to establish artificial limitations or exclusions, which will be countertherapeutic for the patient and limit successful patient outcome. This perspective is also supported in *The Institute of Medicine* publication, "Crossing the Quality Chasm: A New Health System for the 21st Century" (March 2001): "Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place." More than four decades of research have demonstrated that the appropriate use of medications, such as methadone and buprenorphine, to treat chronic opioid dependence/addiction in conjunction with comprehensive need- based treatment services, have proven to be extremely cost effective. Almost all of this treatment is conducted on an outpatient basis as well.

It is also important to point out that there are special federal and state rules governing admission to OTPs in addition to the frequency of patient visits to the treatment program. The federal rules for OTPs with regard to frequency of patient visits are stipulated in 21 CFR Part 291 and 42 CFR Part 8, Opioid Drugs in Maintenance and Detoxification Treatment of Opioid Addiction. These federal regulations are promulgated by DHHS/SAMHSA/CSAT. Illustratively, these federal requirements stipulate "...that a patient is responsible in handling opioid drugs [and that] the following restrictions apply: during the first 90 days of treatment, the take-home supply is limited to a single dose each week and the patient shall ingest all other doses under appropriate supervision as provided for under the regulations in this subpart." It is important that the remaining part of these regulations be understood, as parity legislation will apply to the use of medication-assisted treatment for chronic opioid dependence/addiction.

In summary, we believe that as the above-referenced legislation is being implemented, there should not be any standardized and/or illogical restrictions on the length of time that a patient may need access to treatment or medication, as long as the patient continues to benefit from such care. We appreciate your willingness to take our comments into account as you begin to implement this act.

Sincerely yours,

Mark W. Parrino, MPA
President

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