MEDICARE ADDICTION PARITY Project

2023 Consolidated Appropriations Act:

Medicare Substance Use Disorder and Mental Health Coverage Developments

On December 29, 2022, President Biden signed the Consolidated Appropriations Act (CAA) of 2023 into law. This omnibus legislation included a number of provisions related to improving access to substance use disorder and mental health care in the Medicare program, several of which were key priorities of the Medicare Addiction Parity Project.

Expanding Access to Community-Based Substance Use Disorder Services

Intensive Outpatient Treatment: In response to gaps in the Medicare continuum of care for substance use disorder treatment, the CAA authorized coverage of Intensive Outpatient (IOP) Treatment: a community-based structured program of care for individuals who need a mix of therapies for 9-19 hours a week but are able to reside in their homes and communities. Coverage of IOP, which is available in Medicaid and other financing systems, allows beneficiaries to get more intensive treatment than regular outpatient care, which will prevent unnecessary hospitalization. Hospital outpatient departments, Community Mental Health Centers, Federally Qualified Health Centers, and Rural Health Clinics will be eligible for reimbursement of these services starting January 1, 2024.

Mobile Crisis Care: To provide more timely and responsive psychiatric services for individuals in crisis, the CAA directs the Department of Health and Human Services (HHS) to establish a new code for crisis psychotherapy services that can be delivered at sites other than facilities and office-based settings, which currently bill for this service (CPT codes 90839 and 90840), such that they can be offered by a mobile crisis unit. The new code will go into effect in 2024 and be reimbursed at a 50% higher rate than crisis psychotherapy in facilities and offices. HHS will also to provide education and outreach about this new service and convene stakeholders for an open door forum to discuss Medicare program coverage and payment policies relating to beneficiaries experiencing a mental or behavioral crisis.

Contingency Management: The CAA seeks to address barriers to billing for Contingency Management (CM) -- an evidence-based treatment for substance use disorders that provides motivational incentives to patients for adhering to their treatment plan and goals and one of the only clinically effective treatments for stimulant use disorders. The CAA requires the Inspector General to conduct a review on whether to establish a safe harbor to ensure that providers can deliver CM to Medicare beneficiaries, and will submit recommendations to Congress on ways to improve access to CM interventions while ensuring quality of care, fidelity to evidence-based practices, and strong program integrity safeguards.

Outreach on Behavioral Health Integration and Opioid Treatment Programs: The CAA also requires HHS to conduct several provider outreach and education efforts to improve access to community-based mental health and substance use disorder care that are already covered under Medicare. Specifically, the Secretary of HHS will conduct comprehensive education efforts to inform providers and appropriate non-physician practitioners that behavioral health integration services and opioid treatment services furnished by opioid treatment programs (OTPs) are covered benefits under Medicare, including a description of the requirements to bill for such codes and the eligibility requirements for beneficiaries to receive such services. The OTP education initiative will also include outreach to Medicare beneficiaries. The Secretary will be required to report on the outreach efforts and subsequent utilization rates of these services.

Enhancing the Mental Health and Substance Use Disorder Workforce

Marriage and Family Therapists, Mental Health Counselors, and Professional Counselors: Beginning in January 2024, Medicare will cover and reimburse Marriage and Family Therapists and Mental Health Counselors, including Licensed Professional Counselors and Clinical Professional Counselors. These providers will be reimbursed at 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist. This is comparable to the reimbursement rate for Clinical Social Workers, but below the reimbursement rate for medical non-physician practitioners, pegged at 85% of physicians. While these providers will be eligible to bill in most settings reimbursable under Medicare Part B, they are excluded from the Skilled Nursing Facility Prospective Payment System.

Peer Support Specialists: The CAA also specified that auxiliary personnel, including peer support specialists, can deliver certain mental health and substance use disorder services including the new mobile crisis codes, other behavioral health crisis services, and behavioral health integration services. The Secretary will educate providers of the ability for peers to participate in furnishing these services no later than January 1, 2024.

Psychiatric Residencies: Starting in Fiscal Year 2026, HHS will increase the limit on the number of psychiatry or psychiatric subspecialty residencies – as accredited by the Accreditation Council for Graduate Medical Education for the purpose of preventing, diagnosing, and treating mental health disorders – for qualifying hospitals.

Equitable Coverage of Mental Health and Substance Use Disorder Services in Medicare

Parity: The CAA took an important first step to address the failure of Medicare to adopt the Mental Health Parity and Addiction Equity Act – the anti-discrimination law that ensures equitable access to mental health and substance use disorder services in other insurance plans. It requires the Government Accountability Office (GAO) to conduct a study and report on disparities in mental health and substance use disorder benefits (both required and supplemental) in Medicare Advantage compared to the other benefits offered by such plans and compared to the mental health and substance use disorder benefits under traditional Medicare fee-for-service in Parts A and B. The study shall include an analysis of out-of-pocket expenses for in-network care, the use of prior authorization and other utilization management tools, the mental health and substance use disorder benefits offered, and other items determined appropriate by the GAO.

Psychiatric Inpatient Quality Measures: Finally, the CAA included measures to improve the quality of care Medicare beneficiaries receive in inpatient psychiatric settings, including inpatient psychiatric hospitals and psychiatric units at general hospitals, to be more consistent with other inpatient care. No later than October 1, 2023, HHS will collect additional data and information to revise payments for psychiatric care, and each psychiatric hospital and psychiatric unit will submit standardized patient assessment data to HHS starting in rate year 2028. By rate year 2031, the quality data that psychiatric hospitals and psychiatric units submit to HHS must include a quality measure on patients' perspective of care, ending the outdated and discriminatory practice that limited the experiences of patients with psychiatric diagnoses from being included in quality measures.

Medicare Addiction Parity Project Priorities

	MAPP Recommendation	CAA 2023 Provision	Next Steps
Services	Authorize coverage of and reimburse for Intensive Outpatient (IOP) Services	Authorize coverage of IOP services in hospital outpatient departments, community mental health centers, Federally Qualified Health Centers, and Rural Health Clinics.	1. CMS should adopt regulations that ensure IOP is available for individuals with substance use disorders. 2. CMS should develop crosswalk codes for IOP in Opioid Treatment Programs. 3. CMS should develop crosswalk codes for IOP in office-based settings.
	Remove coverage limitations on Partial Hospitalization (PHP) Services	Not addressed	1. Congress should remove statutory limitations on PHP treatment (i.e. requirement that beneficiary would otherwise need inpatient care).
	Authorize coverage of and reimburse for SUD residential treatment services	Not addressed	1. Congress should authorize coverage of and reimbursement for residential treatment services.
	Authorize coverage of and reimburse for crisis services	Establish payment for mobile crisis psychotherapy at 150% of fee schedule rate.	1. Congress should authorize coverage of the full crisis continuum of care, such as crisis stabilization units.
	Authorize coverage of and reimburse for contingency management (CM) services	Inspector General will review whether to establish a safe harbor for CM and submit recommendations to Congress.	1. CMMI should conduct a demonstration project on CM in Medicare. 2. Congress should leverage the forthcoming report to cover and reimburse for CM in Medicare.
Providers	Authorize coverage of and reimburse Licensed Professional Counselors at a fair rate	Authorize coverage of Licensed (Clinical) Professional Counselors, Marriage and Family Therapists, and Mental Health Counselors. Reimbursement shall be 80% of the lesser of the actual charge for services or 75% of the amount payable to a psychologist.	1. Congress should increase the reimbursement rate for these practitioners – and clinical social workers - so it is consistent with what medical non-physician practitioners are paid. 2. Congress should ensure these practitioners can furnish services in all settings including Skilled Nursing Facilities.
	Authorize coverage of and reimburse Licensed and Certified Substance Use Disorder Counselors	Not addressed	1. CMS should clarify that licensed professional counselors include licensed substance use disorder counselors. 2. Congress should authorize coverage of and reimbursement for certified SUD counselors.
	Clarify coverage of Peer Support Specialists	Provide education and outreach to providers that peer support specialists can participate in furnishing behavioral health crisis services and behavioral health integration services.	1. CMS should clarify that peer support specialists can participate in furnishing other mental health and substance use disorder services along the continuum of care (such as IOP and PHP) and across settings (such as FQHCs and RHCs).
Settings	Authorize coverage of and reimburse Freestanding Community-based Substance Use Disorder Treatment Facilities	Not addressed	1. Congress should authorize coverage of freestanding community-based SUD treatment facilities.
Parity	Apply the Mental Health Parity and Addiction Equity Act to Medicare Parts A, B, C, and D	GAO shall conduct a study comparing the mental health and substance use disorder benefits (both required and supplemental) offered by Medicare Advantage plans with other medical benefits offered by such plans and with the benefits offered under traditional fee-for-service Medicare, and submit a report on the study to Congress.	1. GAO should work with stakeholders to determine "other items" that should be included in the study beyond the required analysis of out-of-pocket expenses for in-network care, prior authorization and utilization management, and what benefits are offered. 2. CMS should address discriminatory coverage, utilization management, network adequacy, and reimbursement standards in traditional Medicare and Medicare Advantage. 3. Congress should leverage the forthcoming report to apply parity to all parts of Medicare.