Cutting Off Care

How the 190-Day Lifetime Inpatient Psychiatric Limit Harms Medicare Beneficiaries with Substance Use Disorders

Medicare is the federal insurance program for older adults (those ages 65 and older) and people with chronic disabilities. Approximately 6.4 million Medicare beneficiaries had a substance use disorder (SUD) in 2023 (including alcohol and drug use disorders).[1] About 2.35 million of these individuals had a co-occurring mental health condition,[2] and Medicare beneficiaries with an SUD are significantly more likely to report past-year serious psychological distress and past-year suicidal ideation than those without an SUD.[3] While the overall drug overdose rates decreased nationally between 2022 and 2023, adults ages 65 and older experienced the largest percentage increase among any age group.[4]

Despite these troubling statistics, Medicare does not cover some necessary treatment settings for people with mental health conditions and SUDs. One of the most restrictive limitations is Medicare's cap on treatment in Inpatient Psychiatric Facilities (IPFs). Beneficiaries can only receive a total of 190 days of treatment in IPFs over the course of their lifetimes. This limit is unique to psychiatric care, and it can have serious consequences for this population.

The Medicare Payment Advisory Commission (MedPAC) issued a report to Congress in March 2025 on Eliminating Medicare's Coverage Limits on Stays in Freestanding Inpatient Psychiatric Facilities. In this report, MedPAC highlighted how a small but vulnerable group of Medicare beneficiaries is affected by the statutory 190-day lifetime limit and estimated that almost 40,000 beneficiaries have reached this lifetime cap as of January 2024, and another 10,000 beneficiaries are within 15 days of the limit. Notably, 34% of these 50,000 individuals have an SUD.

In this issue brief, we discuss the implications of reaching the statutory IPF limit for individuals with SUDs and why it is necessary to end the limitation. In addition, we lay out other policy changes that would further support Medicare beneficiaries with SUDs.

Recommendations

- Remove the 190-day lifetime limit on inpatient psychiatric facility treatment in Medicare.
- Authorize Medicare coverage of non-hospital residential substance use disorder treatment and freestanding community-based substance use disorder treatment facilities.
- Reduce cost-sharing for substance use disorder services and medications in Medicare.
- Improve access to substance use disorder treatment medications in the hospital, at hospital discharge, and in skilled nursing facilities.
- Apply the Mental Health Parity and Addiction Equity Act to Medicare.

Background

Historically, Medicare has had very limited coverage of SUD treatment.[5] Prior to 2020, Medicare beneficiaries had access to hospital-based inpatient care through Part A—which covers hospital care, both in general hospitals as well as in IPFs—as well as outpatient treatment in hospital- and office-based settings through Medicare Part B, but essentially nothing in between. There was no coverage of specialty SUD treatment settings other than at community mental health centers (CMHCs), although these tend to be more focused on treating mental health conditions. As a result, the vast majority of Medicare beneficiaries who received SUD treatment in 2020 did so in hospitals.[6]

Almost 40% of inpatient psychiatric care for Medicare beneficiaries was provided in either public or private IPFs in 2023.[7] As of January 2024, more than 800,000 beneficiaries had received coverage for at least one day in an IPF.[8] As noted above, treatment in these facilities is subject to quantity limits under federal law. Medicare beneficiaries can only receive a total of 190 days of treatment in IPFs over the course of their lifetimes, and new beneficiaries are subject to a reduction in covered days if they were receiving treatment in IPFs on – or in the 150 days prior to – the first day they were entitled to Medicare.[9] This lifetime limit is unique to psychiatric care – there is no lifetime limit for any other type of hospitalization or health condition.

Together, Congress and the Centers for Medicare & Medicaid Services (CMS) have made important progress in recent years to expand and improve coverage of SUD treatment in Medicare across the continuum, but notable gaps still remain.[10] In particular, Medicare still does not cover non-hospital residential SUD treatment or community-based SUD treatment facilities other than opioid treatment programs (OTPs). For many individuals, these gaps translate to limited options for SUD treatment when their conditions are less severe so as to prevent hospitalizations or emergency department visits. For those with more acute conditions, there are similarly limited options for step-down and follow-up care after a hospitalization or emergency department visit. Additionally, although medications for opioid use disorder (MOUD) are the gold standard of treatment, fewer than one in five Medicare beneficiaries with an opioid use disorder receive these medications,[11] compared to two-thirds of Medicaid enrollees.[12] Furthermore, only about two in five Medicare beneficiaries who started treatment with buprenorphine (the most commonly used MOUD in Medicare) continued for at least six months – the quality standard used by CMS.[13]

Medicare beneficiaries with an SUD have disproportionately high hospital readmission rates compared to those who do not have an SUD.[14] While many reasons could account for this disparity, one indisputable and critical factor is the low rate at which these individuals receive appropriate SUD care at discharge or in follow-up after a hospitalization. Claims and encounter data reveal that only 31% of Medicare beneficiaries received follow-up care within seven days after a hospitalization for an opioid use disorder, and only 38% received follow-up care within 30 days.[15] Among fee-for-service (FFS) Medicare (or traditional Medicare) beneficiaries who had a nonfatal overdose in 2020, only 4.1% received medications for opioid use disorder (MOUD),

18% received psychotherapy or counseling, and 40.9% received treatment or recovery support.[16] Similarly, among Medicare beneficiaries who had an alcohol-related hospitalization in 2016, only 2% involved a discharge with medications for alcohol use disorder (MAUD).[17]

Because community-based SUD care and post-hospital follow-up care are so limited for Medicare beneficiaries, it is not surprising that there is such a high reliance on hospital-based settings for this population. However, it leads to a cyclical pattern of hospital and emergency care that fails to address the underlying treatment needs of this population, and increases the likelihood that they will hit the 190-day treatment limitation for inpatient psychiatric care.

Implications of the IPF Lifetime Limit for Medicare Beneficiaries with SUD

Among FFS Medicare beneficiaries who were at or near the lifetime limit for IPF covered days, approximately 34% had an SUD, most of whom had a co-occurring mental health condition.[18] Inpatient psychiatric treatment is already very costly for these individuals – they are subject to the Part A deductible, as well as increasing amounts of co-insurance as their hospital stays continue beyond 60 days.[19] The majority of Medicare Advantage plans have additional co-pays for these hospitalizations.[20] One of the most commonly reported reasons for Medicare beneficiaries to not receive SUD treatment was financial barriers.[21] Many Medicare beneficiaries are living on fixed or low incomes with limited savings and assets[22] and cannot afford to pay out of pocket for treatment that their insurance does not cover.

According to the MedPAC report, approximately 20% of Medicare beneficiaries who are at or near the lifetime limit for IPF covered days have other insurance that may cover additional IPF days. For example, some Medicare Advantage plans offer supplemental benefits that go beyond what FFS Medicare covers, and 8% of these plans offer additional IPF days[23] – affecting about 5% of the Medicare beneficiaries who are at or near the lifetime limit. Another 15% of Medicare beneficiaries at or near the IPF lifetime limit are dually eligible for Medicaid and aged 65 or older, such that their Medicaid coverage may pay for additional IPF days. However, for the 50% of dually eligible Medicare beneficiaries at or near the lifetime limit who are under age 65, their Medicaid coverage would likely not pay for additional IPF days because of the Medicaid institutions for mental diseases (IMD) exclusion.[24] The other 30% of Medicare beneficiaries at or near the lifetime limit likely do not have any coverage that would pay for IPF care beyond the 190-day lifetime limit either.

For individuals who continue to need hospital-level care beyond the 190-day lifetime limit, one option is to transfer to a general acute care hospital, rather than an IPF, as these facilities are not subject to the same limitation. However, these general hospitals may lack the specialty providers, resources, and expertise needed to treat these individuals, especially for the many beneficiaries who have co-occurring SUD and mental health conditions at or near the lifetime limit.

For those who still need treatment in a residential setting but may not need all the medical providers and resources a hospital provides, Medicare beneficiaries with an SUD have fewer options. FFS Medicare does not cover non-hospital residential SUD treatment, and less than 1% of Medicare Advantage plans offer residential SUD treatment as a supplemental benefit.[25] Medicare covers post-hospital skilled nursing facility (SNF) care after an individual has been inpatient for three days. However, it is notable that Medicare beneficiaries who are hospitalized for an opioid use disorder and who have a primary diagnosis of opioid use disorder are least likely to be discharged to an SNF than any other type of facility.[26] Unfortunately, SNFs frequently discriminate against and refuse to admit patients with an opioid use disorder and/or those who are taking MOUD, even though doing so is illegal under multiple federal laws.[27] Accordingly, the IPF treatment limitation, compounded by these other treatment gaps and barriers, merely cuts off care for the Medicare beneficiaries who need it.

Recommendations

As the rates of SUD and overdose continue to increase among older adults, Congress and CMS must continue to improve access to necessary care and coverage for Medicare beneficiaries. Eliminating the arbitrary treatment limitation on IPFs should be coupled with removing barriers to less intensive and less expensive community-based care so that all individuals have access to the most appropriate treatment in the least restrictive setting.

Remove the 190-day lifetime limit on inpatient psychiatric facility treatment in Medicare.

Eliminating the IPF lifetime limit, consistent with MedPAC's recommendation, will have a minimal cost impact on the Medicare program or federal budget but will ensure that this particularly vulnerable population can continue to receive the most appropriate care they need to effectively treat their SUD or mental health condition. Congress should pass the Medicare Mental Health Inpatient Equity Act, as previously introduced in multiple sessions.[28]

Authorize Medicare coverage of non-hospital residential SUD treatment and freestanding community-based SUD treatment facilities.

To prevent Medicare beneficiaries from needing costly inpatient services, and to ensure they can get appropriate follow-up care after a hospitalization or emergency department visit, Congress should authorize Medicare coverage of non-hospital residential SUD treatment by passing the Residential Recovery for Seniors Act.[29] Additionally, Congress should authorize Medicare coverage of freestanding community-based SUD treatment facilities, to ensure that outpatient and residential SUD treatment services are meaningfully available to older adults and people with disabilities, and limit unnecessary hospital services.

Reduce cost-sharing for SUD services and medications in Medicare.

Congress has eliminated cost-sharing for OTP services for beneficiaries in FFS Medicare, but cost-sharing for individuals in Medicare Advantage plans and for all beneficiaries seeking any other SUD services or medications remains a significant

barrier. As such, Congress should remove cost-sharing for other SUD treatment services and medications in FFS Medicare, Medicare Advantage, and Part D Prescription Drug Plans. CMS should finalize the proposal to align Medicare Advantage cost-sharing for SUD and mental health services with FFS Medicare.[30]

Improve access to SUD treatment medications in the hospital, at hospital discharge, and in skilled nursing facilities.

CMS should require all hospitals and SNFs to ensure access to SUD treatment medications (including MOUD and MAUD) as a Condition of Participation, either directly or through partnerships with prescribers and facilities that offer these medications. CMS can further improve access to these life-saving medications by increasing reimbursement rates for all practitioners and facilities that provide them.[31]

Apply the Mental Health Parity and Addiction Equity Act to Medicare.

The 190-day lifetime limit on IPFs would be an illegal quantitative treatment limitation under the Mental Health Parity and Addiction Equity Act (MHPAEA) if it were to apply to Medicare in the same way this non-discrimination law applies to other types of insurance.[32] In addition to removing this and other statutory limitations that restrict access to SUD and mental health care, Congress should apply MHPAEA to all Parts of Medicare to require that, as written and in practice, coverage of benefits for these conditions is equitable. Doing so will ensure meaningful access to SUD and mental health care and save lives.

Conclusion

The U.S. is still losing far too many lives to overdose and other health conditions that are caused or exacerbated by untreated SUD. These policy recommendations are cost-effective and necessary to save lives and improve access to treatment. MedPAC estimates that eliminating the IPF lifetime limit would cost a mere $40 million—less than 0.04% of Medicare spending.[33] Authorizing coverage of residential SUD treatment would also have a minimal cost-impact on federal spending[34] but a life-changing effect on Medicare beneficiaries with an SUD. These policy changes, as well as reducing cost-sharing, improving access to MOUD in hospitals and post-hospital discharge settings, and applying MHPAEA to Medicare, will remove discriminatory barriers that older adults and people with disabilities with an SUD currently face. It is time to stop cutting off care that people need.

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