

Out of Reach: How Gaps in Medicare Coverage of Substance Use Disorder Care Harm Beneficiaries

[4.3 million](#) adults ages 65 and older have a substance use disorder, yet few older adults receive treatment through Medicare. Medicare has significant coverage [gaps](#) for substance use disorder treatment that prevent the vast [majority](#) of beneficiaries from getting the treatment they need. More than [half](#) of beneficiaries are now enrolled in Medicare Advantage (MA) plans, which impose even greater [limitations](#) on treatment. These barriers disproportionately affect lower income, dually eligible, and Black and brown individuals who enroll in MA plans at [higher](#) rates than white beneficiaries.

Fatal overdoses among older adults have [quadrupled](#) in the past two decades.

The prevalence of substance use disorder is about [4 times](#) higher among Medicare beneficiaries under age 65 than for those over age 65.

Congress and the Centers for Medicare & Medicaid Services (CMS) have adopted important, yet incremental, measures to improve Medicare coverage of substance use disorder care. To fully meet beneficiary needs, structural changes are necessary to align Medicare coverage with community-based care delivery models that are reimbursed in Medicaid, private health plans, and employer-sponsored plans. Without improved coverage and application of the Mental Health Parity and Addiction Equity Act (Parity Act) to Medicare, older adults and people with disabilities will continue to face unnecessary burdens and barriers to care that often compound to make treatment unaffordable and inaccessible.

The following stories submitted by people across the country illustrate common experiences of Medicare beneficiaries with substance use disorders. *(Note: Names have been changed, and stories have been de-identified to protect individuals' privacy.)*

Non-Covered Substance Use Disorder Treatment Facilities

Medicare fails to cover community-based substance use disorder treatment facilities that are not affiliated with a hospital system or opioid treatment program. These settings generally offer multiple levels and types of substance use disorder care to deliver a continuum of appropriate treatment. Importantly, they deliver more of the intermediate and intensive levels of care than the currently covered office-based settings. Thus, even when services are covered by Medicare, beneficiaries are not able to access care that is available to people with other types of coverage such as Medicaid or commercial insurance. This facility-type limitation would likely be a violation of the Parity Act if the law applied to Medicare, as it disproportionately limits the scope, location, and duration of benefits and services that people with substance use disorders can receive, in a way that is not comparable to Medicare coverage for other medical conditions.

Harry and April's efforts to access substance use disorder treatment demonstrate the real-life impact of Medicare's failure to cover community-based treatment facilities.

Harry, a 23-year old man in Wisconsin who suffered a traumatic brain injury, developed a substance use disorder after his injury, and required more intensive services than outpatient care. He was unable to receive treatment because Medicare does not cover community-based substance use disorder treatment facilities and Medicare's partial hospitalization benefit does not align with how the service is delivered for individuals with substance use disorders. When Harry's guardian tried to help him access treatment, Harry's provider determined that the most appropriate level of care for him would be a partial hospitalization program (PHP) or intensive outpatient program (IOP) that could focus on his co-occurring conditions. However, the only PHP or IOP in the city in which Harry resides is at a freestanding community-based substance use disorder treatment facility, which is not covered by Medicare. The mental health facilities in their area that do accept Medicare do not have the staff to address the substance use portion of Harry's needed treatment. Harry and his guardian are unable to afford to pay for the treatment out-of-pocket, so he is foregoing medically necessary treatment for his substance use disorder because of Medicare's coverage limitations on settings of care and PHP.

April, a 77-year old woman who lives in New York, was forced to incur significant medical debt because Medicare does not cover community-based substance use disorder treatment facilities and her Medicare Advantage (MA) plan had an inadequate network of covered providers. April's alcohol use disorder began in 2018, and got progressively worse until 2021 when she decided to seek treatment. She and her husband searched for in-network providers, but there was only one facility in her MA plan's network that provided inpatient withdrawal management, and Medicare does not cover residential treatment in community-based substance use disorder treatment facilities. April was forced to go to an out-of-network facility and pay \$14,000 out-of-pocket, with the assurance from the facility and her MA plan that she could be reimbursed.

Following her 28-day program, April and her husband called her plan multiple times to learn what to submit, and they sent the required paperwork to her MA plan. Nonetheless, the MA plan denied the claim two months later due to "incomplete information." After submitting additional information, the MA plan denied her reimbursement again, this time because she had failed to obtain a prior authorization for her treatment, even though she was never informed of this requirement. They appealed the denial again, only to be denied once more because the facility was not a Medicare-covered facility.

While April's recovery was ultimately successful, she was forced to pay the full cost of treatment and undergo this lengthy, futile battle with her MA plan, which took a significant mental toll due to Medicare's failure to cover community-based substance use disorder treatment facilities and the plan's inadequate network of inpatient substance use disorder treatment.

Recommendation: Congress must authorize Medicare coverage of community-based substance use disorder treatment facilities where beneficiaries can get the range of care they need. Congress must also apply the Parity Act to Medicare.

Gaps in the Continuum of Care

Medicare covers the least intensive and most intensive types of treatment but fails to cover intermediate levels of care for people with substance use disorders. This bookended approach is inconsistent with the American Society of Addiction Medicine (ASAM) Criteria, which classifies

substance use disorder treatment on a continuum, like other chronic disease care models. Medicare covers early intervention and outpatient services (ASAM Levels 0.5 and 1) and inpatient services (ASAM Level 4). It lacks coverage for residential services (ASAM Level 3), and Medicare's benefit design for intensive outpatient (beginning in 2024) and partial hospitalization (ASAM Level 2) fail to meet the needs of beneficiaries with substance use disorders. Without this service coverage, Medicare beneficiaries cannot receive the most appropriate care in the least restrictive setting, resulting in many individuals getting inadequate, if any, treatment until their conditions become acute enough to require hospitalization. These coverage limitations would likely be a violation of the Parity Act if applied to Medicare, as they disproportionately limit the scope of benefits that people with substance use disorders can receive in a way that is not comparable to Medicare coverage for other medical conditions.

Similar to Harry and April, Michelle's efforts to access intermediate levels of substance use disorder treatment demonstrate the real-life struggle to get the appropriate level of care in Medicare.

Michelle lives in the Midwest and was unable to get the appropriate care she needed because of Medicare's failure to cover the full continuum of substance use disorder treatment. Michelle had tried outpatient substance use disorder treatment in her area, but she was unsuccessful. Previously, she had received treatment at a hospital 3.5 hours away, which had been more successful, so she returned to that facility's outpatient clinic despite the significant travel time and distance, likely in violation of Medicare's travel time and distance standards for network adequacy.

At the clinic, her provider determined that her condition was too severe to be treated in an outpatient setting, and she was admitted to the hospital's inpatient unit for medically supervised withdrawal management for five days. Once she had completed her withdrawal management, her condition was still too severe for outpatient treatment, but no longer severe enough for ongoing inpatient treatment. However, the provider was unable to identify any programs in the state that could provide residential treatment, partial hospitalization, or intensive outpatient that treat people with substance use disorders and take Medicare.

Michelle was discharged to her home, and she never received the more intensive counseling and therapy services for which she had sought treatment because her condition remained too severe for outpatient care but was not severe enough for ongoing inpatient care. As a result, Michelle is foregoing medically necessary treatment that would allow her to maintain her recovery because of Medicare's failure to cover the full continuum of substance use disorder treatment.

Recommendation: Congress must authorize Medicare coverage of residential substance use disorder treatment and align the partial hospitalization and intensive outpatient Medicare benefits with the evidence-based treatment services for patients with a primary substance use disorder diagnosis to close the gaps in the continuum of care. Congress must also apply the Parity Act to Medicare.

Gaps in Provider Coverage

Although Congress recently authorized coverage of marriage and family therapists and mental health counselors to deliver mental health care starting in 2024, Medicare still does not explicitly cover licensed and certified substance use disorder counselors – who make up a significant segment of the

addiction treatment workforce. This coverage limitation would likely be a violation of the Parity Act if applied to Medicare, as it disproportionately limits the scope of benefits that people with substance use disorders can receive, in a way that is not comparable to Medicare coverage for other medical conditions.

Nancy's story highlights how Medicare's lack of coverage of licensed and certified substance use disorder counselors prevented her from getting the opioid use disorder treatment she needed.

Nancy is a 50-year old woman from North Carolina who was unable to get the opioid use disorder treatment she needed because of Medicare's failure to cover licensed and certified substance use disorder providers. Nancy lives in a rural county that has only one substance use disorder clinic, which is staffed by Licensed Clinical Addiction Specialists and Certified Alcohol and Drug Counselors. Even if the new Medicare rules – authorizing coverage of marriage and family therapists and mental health counselors – were in effect, Nancy still would not have been able to seek treatment from any of these mental health providers because, under North Carolina law, only professionals who are licensed or certified through the North Carolina Addictions Specialist Professional Practice Board can provide substance use disorder treatment. If Nancy had Medicaid or commercial insurance, she would have been able to get care from these providers, but she had no secondary insurance.

The clinic was forced to refer Nancy to a clinic in another county that had dually licensed mental health and substance use disorder providers who could treat her. However, Nancy is enrolled in Medicare due to her disability, and she does not have access to transportation. Thus, Nancy cannot access the outpatient provider and Nancy is forgoing treatment for her opioid use disorder as a result of Medicare's failure to authorize and reimburse licensed and certified substance use disorder providers.

Recommendation: Congress must authorize Medicare coverage of licensed substance use disorder counselors, and certified counselors under supervision, so beneficiaries can access the full addiction treatment workforce. Congress must also apply the Parity Act to Medicare. In implementing regulations to cover mental health counselors, CMS should define those providers to include substance use disorder counselors who are licensed by the State and meet the education and training requirements.

Inadequate Networks of Providers

Although Medicare Advantage (MA) plans are required to maintain provider networks sufficient to meet the needs of their beneficiaries, they routinely fail to do so, such that beneficiaries are forced to forego needed treatment, travel great distances, or pay greater costs to get treatment out-of-network. This problem is exacerbated by Medicare's lack of coverage of many of the providers in the addiction workforce, including licensed and certified substance use disorder counselors. CMS cannot readily track these deficiencies because it does not have any distinct metrics of demonstrating network adequacy for substance use disorder providers, even though it includes them in certain mental health specialties. The lack of oversight or accountability allows MA plans to offer inadequate networks of substance use disorder providers. Because Medicare is not subject to the Parity Act, MA plans may also use policies and practices to restrict their networks for substance use disorder providers to a greater extent than they do for other medical providers. Beginning in 2024, MA beneficiaries should be

able to pay in-network cost-sharing rates for such services when their plans' networks are inadequate, but CMS has yet to issue guidance on how beneficiaries can demonstrate inadequate networks to take advantage of this right.

In addition to Michelle and April's experiences, Mary's story highlights another way that inadequate Medicare networks prevented her from getting the substance use disorder treatment she needed.

Mary is a 73-year old Medicare beneficiary living in California who has been unable to get the alcohol use disorder treatment she needs because her MA plan has an inadequate network for substance use disorder treatment itself and for programs that treat co-occurring mental impairments and refuses to refer her to out-of-network care.

Mary's MA plan covers only one substance use disorder treatment program, which prohibits the use of cannabis even though it is legal in the state and Mary uses it a means of harm reduction for her very serious alcohol use disorder. Mary has made several attempts to reduce her drinking on her own, but she required hospitalization for alcohol withdrawal on multiple occasions. Each time, she was referred back to this same program in her MA plan's network. She has attempted to participate in this program on multiple occasions over the past decade, but she has always been discharged due to her cannabis use and never given a referral to another program.

Presently, Mary's memory is becoming increasingly impaired beyond that of her peers because of her ongoing alcohol use and she has developed several other health problems related to her alcohol use disorder. She cannot retain important information that allows her to communicate with others, and she is beginning to miss social cues in human interactions. She cannot remember how much alcohol she consumed throughout the day and night. Soon she will need in-home caregivers and supports because of her rapidly deteriorating condition. Her daughter remains unable to find any programs in her MA plan's network that can treat Mary's alcohol use disorder in a way that meets her needs.

Recommendation: Congress must apply the Mental Health Parity and Addiction Equity Act to Medicare to eliminate these non-quantitative treatment limitations that prevent beneficiaries with substance use disorders from getting the full scope and duration of treatment they need. CMS must develop network adequacy standards and reporting requirements specifically for substance use disorder providers for Medicare Advantage plans and ensure meaningful oversight and accountability of networks.

Prior Authorization Practices

While traditional Medicare beneficiaries can seek care without first getting approval, Medicare Advantage (MA) plans frequently require prior authorizations before a beneficiary can receive treatment, at an especially high rate for substance use disorder and mental health treatment. These practices lead to delays and denials of care that should otherwise be covered under Medicare rules. While CMS has issued new regulations to attempt to limit the inappropriate use of prior authorization practices beginning in 2024, there are no requirements for oversight and accountability. Furthermore, because Medicare is not subject to the Parity Act, MA plans may still use more stringent prior authorization practices for substance use disorder care than for other medical conditions.

Betsie and Laura's experiences trying to access substance use disorder treatment demonstrate how MA plans use prior authorization practices to delay and deny patients the substance use disorder treatment they need.

Betsie, a 58-year old woman who lives on the east coast, was unable to get timely access to inpatient substance use disorder treatment because her MA plan failed to respond to her expedited prior authorization in a timely manner. After completing hospital-based withdrawal management in the summer of 2022, Betsie's provider recommended she get inpatient substance use disorder treatment and submitted an expedited prior authorization to her MA plan. In the process of seeking treatment, Betsie lost her housing, and if she was not admitted to the program, she would not have had any housing or support to continue with her recovery on an outpatient basis.

After 72 hours, her MA plan had still not responded to the expedited prior authorization request, and Betsie was not getting the full range of services she needed to progress in her recovery. Eventually, the prior authorization was approved, but such a delay in treatment – including the additional costs of remaining in the inappropriate setting of care – would not have occurred if her MA plan maintained comparable prior authorization policies and procedures for substance use disorder treatment as it does for medical and surgical treatment, as would be required under the Parity Act.

Laura, a MA beneficiary in Michigan, suffered a relapse from her alcohol use disorder because her MA plan failed to respond to her provider's prior authorization request in a timely manner and applied overly stringent medical necessity criteria, and because Medicare fails to cover the full continuum of substance use disorder treatment. Laura went to a hospital emergency room on a Friday night for treatment for her alcohol use disorder. The hospital submitted paperwork to her MA plan to try to place Laura in its medically supervised withdrawal management unit, which provides the full scope of services necessary to help patients withdraw from substances and begin to address their condition. However, this MA plan does not review prior authorizations over the weekend, so Laura stayed in the emergency room for two days, only receiving the medical services required for her withdrawal management.

At the beginning of the business week, the MA plan claimed it had not received the prior authorization request, but also determined that Laura was no longer eligible for ongoing inpatient treatment because she had completed the medical portion of her withdrawal management. Accordingly, Laura was discharged home, without having accessed any of the counseling, group therapy, or recovery supports that her provider determined she needed. Such services would have been available to Laura in the inpatient unit or in an intermediate level of care such as residential treatment or partial hospitalization, but these lower levels of care were not available to her as a Medicare beneficiary.

Laura returned to the hospital's outpatient clinic for a follow up visit two weeks later, seemingly maintaining her recovery. However, within the next month, Laura had resumed alcohol use. Ultimately, Laura came back to the emergency room, this time on a weekday when her plan was able to process the request without the weekend delay for inpatient withdrawal management. She was able to get the treatment she needed that allowed her to fully engage in withdrawal management and she was then discharged safely to the outpatient department for ongoing follow up care. Laura has remained in recovery. The MA plan's failure to timely respond to the prior authorization request, its stringent use of medical necessity criteria, and Medicare's failure to cover intermediate levels of care in community-based office settings prevented her from maintaining her recovery when she initially sought treatment and resulted in unnecessary costs and hardship.

Recommendation: Congress must apply the Mental Health Parity and Addiction Equity Act to Medicare to eliminate these non-quantitative treatment limitations that prevent beneficiaries with substance use disorders from getting the full scope and duration of treatment they need. CMS must ensure meaningful oversight and accountability of MA plans' use of prior authorization practices, as well as all other forms of utilization management and policies that discriminatorily limit the scope and duration of care.

Stringent Medical Necessity Criteria

Although CMS has issued new regulations that should require Medicare Advantage (MA) plans to use medical necessity criteria that are consistent with those used in traditional Medicare, MA plans are still able to develop or purchase additional criteria that further limit access to substance use disorder care. Frequently, plans require individuals to be experiencing acute medical symptoms to access care, even though substance use disorders are chronic conditions for which a wide range of factors may require more intensive levels of treatment. Such factors are documented in the ASAM Criteria, which CMS has recommended, but not required, MA plans use when determining medical necessity. Because Medicare is not subject to the Parity Act, MA plans may use more stringent medical necessity criteria for substance use disorder care than for other medical conditions.

Similar to Laura's inability to get the treatment she needed because of overly stringent medical necessity criteria, Arnold was not able to get the medications he needed because of his MA plan's policies.

Arnold, a 62-year old man living in the southwest, was denied coverage of his medication for opioid use disorder because his Medicare Advantage (MA) plan determined it was not medically necessary; a determination that is inconsistent with clinical guidelines, traditional Medicare standards, and practices for medications for medical conditions. Arnold became addicted to pain killers after he was injured in a work-related accident. In 2016, he enrolled in an opioid treatment program – the only provider of medication for opioid use disorder in his area – and has participated successfully in treatment since then. In 2022, Arnold's MA plan issued a denial notice, stating that his treatment was not medically necessary. His life-saving treatment costs \$400 each month. Arnold lives solely on his Social Security Disability Insurance and cannot afford to pay for the treatment out-of-pocket.

The denial of Arnold's ongoing medication would likely be impermissible under Parity Act standards, as the application of medical necessity standards for substance use disorder care appears more stringent than standards for medications for a chronic medical condition.

Recommendation: Congress must apply the Mental Health Parity and Addiction Equity Act to Medicare to eliminate these non-quantitative treatment limitations that prevent beneficiaries with substance use disorders from getting the full scope and duration of treatment they need. CMS must ensure meaningful oversight and accountability of MA plans' use of medical necessity criteria, as well as all other forms of utilization management and policies that discriminatorily limit the scope and duration of care.

Closing the Gaps in Substance Use Disorder Care

As more Medicare beneficiaries experience substance use disorders and fatal overdoses continue to increase at alarming rates among this population, Congress and CMS must address the ongoing barriers to substance use disorder treatment that real people are facing every day.

1. Congress must apply the Mental Health Parity and Addiction Equity Act to Medicare to eliminate non-quantitative treatment limitations that prevent beneficiaries with substance use disorders from getting the full scope and duration of treatment they need.
2. Congress must authorize Medicare coverage of community-based substance use disorder treatment facilities where beneficiaries can get the range of care they need.
3. Congress must authorize Medicare coverage of licensed substance use disorder counselors, and certified counselors under supervision, so beneficiaries can access the full addiction treatment workforce. In implementing the coverage of mental health counselors, adopted under the Consolidated Appropriations Act of 2023, CMS should define those providers to include substance use disorder counselors who are licensed by the State and meet the education and training requirements.
4. Congress must authorize Medicare coverage of residential substance use disorder treatment and align the partial hospitalization and intensive outpatient Medicare benefits with the evidence-based treatment services for patients with a primary substance use disorder diagnosis to close the gaps in the continuum of care.
5. CMS must develop network adequacy standards and reporting requirements specifically for substance use disorder providers for Medicare Advantage plans.
6. CMS must ensure meaningful oversight and accountability of Medicare Advantage plans' use of prior authorization, medical necessity criteria, and network adequacy practices, as well as all other forms of utilization management and policies that discriminatorily limit the scope and duration of care.