MEDICARE ADDICTION PARITY Project

The Path to Parity:

Applying the Parity Act to Medicare to Improve Access to Substance Use Disorder and Mental Health Care

DISPARITY IN MEDICARE

The Mental Health Parity and Addiction Equity Act (Parity Act) of 2008 requires most individual and employer-sponsored health plans and Medicaid plans to offer substance use and mental health benefits at the same level as, and with no more restrictive standards than, medical and surgical benefits. The Parity Act bars more restrictive financial requirements, quantitative treatment limits, and other non-quantitative plan design features that limit the scope or duration of care. **This non-discrimination law does not apply to Medicare.** As a result, Medicare beneficiaries do not have coverage of or access to all evidence-based services for substance use disorder (SUD) and mental health (MH), face greater limitations on the settings and providers that offer treatment, and may face more obstacles to getting covered care than individuals who have other types of insurance.

"As the client aged, his number one fear was transitioning to Medicare coverage because he knew that he would lose all of his medical providers, and perhaps most importantly, he would lose access to his therapist. This client also knew that the services available to him through Medicare would not be adequate to meet his needs. As we approached this pending transition in his insurance status, the client asked every week, **'Do I still have to transition to Medicare? I don't want to lose all of my support.'"**

- Shared by a provider of patient facing Medicare eligibility.

Medicare Falls Short

A staggering 93% of Medicare beneficiaries ages 65 and older with a SUD do not receive treatment, nor do an estimated 1 in 3 with MH needs. Because Medicare is not subject to the Parity Act, millions of individuals cannot get the treatment they need, and often lose access to treatment they were receiving prior to becoming eligible for Medicare. Congress has eliminated disparate financial requirements for Medicare beneficiaries, but Medicare still imposes both quantitative and non-quantitative treatment limitations (NQTLs) that would violate the Parity Act.

Medicare Standards that would be in Violation of the Parity Act	
Quantitative Treatment Limitations	Medicare has separate quantitative treatment limitations for MH and SUD. • Inpatient MH and SUD care is limited to 190-days in a beneficiary's lifetime, while no such limit exists for medical/surgical care.
NQTL: Scope of Services	Medicare does not offer the full scope of services for MH and SUD, unlike coverage of sub-acute levels of medical care. • Medicare does not cover intensive outpatient, partial hospitalization, or residential treatment for SUD.
NQTL: Provider Access and Network Adequacy	Medicare does not cover the full range of MH and SUD providers and settings or maintain adequate networks, limiting when and how services are covered. • Medicare does not cover Licensed Professional Counselors, Licensed and Certified Addiction Counselors, or Peer Support Specialists. • Reimbursement rates for non-physician MH and SUD providers are lower than those for non-physician medical and surgical providers. • Part C plans have limited MH and SUD provider networks and standards for network adequacy.
NQTL: Utilization Management Practices	Utilization management practices and standards are not comparable. • Medical necessity criteria can be applied more stringently for MH and SUD care, and beneficiaries do not know why services are denied. • Part C and Part D plans require more frequent prior authorizations and more restrictive step therapy, dosage requirements, and formulary designs for MH and SUD services and prescriptions.

CONGRESS MUST APPLY THE PARITY ACT TO MEDICARE

Applying the Parity Act to Medicare is the critical next step to make MH and SUD services available and accessible to Medicare beneficiaries in need of treatment. Congress can add parity standards to each Medicare Part – Part A (hospital insurance), Part B (medical insurance), Part C (Medicare Advantage), and Part D (prescription drug coverage) – based on the Public Health Service Act (§ 2726; 42 U.S.C. 300gg-26), which requires parity in Medicaid, state-regulated health plans, and state government plans. The Centers for Medicare & Medicaid Services (CMS) would develop regulations, guidance, and frequently asked questions to implement the Parity Act, just as this agency has already done for Medicaid, and build on the decade-long expertise it and the Department of Labor have developed in interpreting and applying the Parity Act.

> "I have not been able to find a provider that works with people whose memory and cognition is impaired due to alcohol – there is nothing at the intersection of aging and addiction. Our family has been in this situation literally for years...we feel Medicare has failed us."
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> - Shared by a daughter who has struggled for years to get adequate care for her mother

To implement the Parity Act in **Medicare Parts A and B**, CMS could directly or through an independent auditing agency evaluate and update written policies and standards, including reimbursement rate setting practices, and document parity compliance. CMS would be responsible for ensuring ongoing compliance and would develop and evaluate national and local coverage determinations and Medicare Administrative Contractor practices consistent with Parity Act requirements, such as no more stringent or restrictive utilization management practices or medical necessity criteria. **Parts C and D plans** would conduct and submit compliance reports directly to CMS for review, just as commercial plans currently submit their reports to state or federal regulators. CMS could also review data on service denials, out-of-network usage, and other features affecting access to care to assess the plans' compliance with the Parity Act "in operation." CMS would enforce these provisions by reviewing contracts and compliance reports, auditing, and imposing sanctions, as needed.

Medicare Parts A and B

The Parity Act would require MH and SUD benefits offered in Medicare Parts A and B to be at the same level and as, and with no more restrictive standards than, medical and surgical benefits offered in Part A or B, respectively. With corresponding statutory amendments, the Parity Act would:

- Eliminate existing and bar future discriminatory **quantitative treatment limitations** like the 190-day lifetime limit on inpatient psychiatric treatment that do not exist for medical treatment.
- Cover **American Society of Addiction Medicine (ASAM) intermediate services for SUD:** Level 2 intensive outpatient programs and partial hospitalization programs and Level 3 residential treatment.
- Cover the **community-based treatment settings** in which outpatient and intermediate care are delivered, similar to the coverage of Opioid Treatment Programs, Community Mental Health Centers, and Comprehensive Outpatient Rehabilitation Facilities.
- Cover the full range of MH and SUD **providers** including Licensed Professional Counselors, Licensed and Certified Addiction Counselors, Marriage and Family Therapists, and Peer Support Specialists.
- Prohibit the use of more stringent **utilization management** standards for MH and SUD treatment, such as more detailed and frequent prior authorizations and concurrent review and restrictive applications of medical necessity criteria.
- Require the same factors that are used to do determine and implement **reimbursement rates** for medical/surgical providers be used for determining reimbursement rates for MH and SUD providers, which would expand the Medicare workforce.
- Establish **reporting requirements and auditing policies** to ensure appropriate transparency and oversight of how Parts A and B, including Medicare Administrative Contractors (MACs), are complying with the Parity Act requirements to provide non-discriminatory coverage for MH and SUD benefits.

Medicare Parts C and D

Under the Parity Act, Medicare Parts C and D plans would be subject to all of the same improvements as Medicare Parts A and B and would be further prevented from imposing additional barriers to care that are all too common among these private insurers. The Parity Act would:

- Prohibit the use of more restrictive **utilization management practices** – such as prior authorizations, step therapy, and formulary design – for MH and SUD services.
- Require **network adequacy** practices for MH and SUD providers – including reimbursement rate setting standards, network admission standards, and credentialing – to be no more restrictive than those for medical/surgical providers.
- Ensure that practices for selecting/developing and applying **medical necessity criteria** for MH and SUD services and medications are no more restrictive than those for medical/surgical benefits, and that these criteria are available to beneficiaries.
- Establish **reporting requirements, auditing policies, and sanctions** for Parts C and D plans to ensure appropriate transparency and oversight of Parity Act compliance.

"Spent hours and hours on the phone, being passed around, and never found anything that was available within 1 month from then. I was placed on long waiting lists, and by the time the services were available, [the Medicare beneficiary] was using again and was no longer willing to get treatment."

- Shared by a family member of someone with a SUD whose Medicare Advantage plan had an inadequate network

"I wanted inpatient long-term treatment, about 60 days, but was denied after 10 days because it wasn't deemed 'medically necessary.'"

- Shared by an individual who sought treatment for opioid use disorder under their Medicare Advantage plan.

"These [Medicare Advantage plans] don't have contracts with us. We learned that getting paid from them is basically impossible because they have so many barriers…Getting an authorization from all these folks basically takes an act of Congress."

- Shared by an Opioid Treatment Program medical director struggling to participate in Medicare Advantage plans.

UNIVERSAL ACCESS TO NON-DISCRIMINATORY SUD & MH BENEFITS

Consistency Across Payers: Applying the Parity Act to Medicare will establish more consistent requirements for non-discriminatory coverage across health care financing systems; standards that carriers offering Part C plans have been otherwise subject to since 2008. While Medicare is often used as the benchmark for critical plan design features in Medicaid and commercial insurance, such as network adequacy and reimbursement, those standards have never been tested for Parity Act compliance and are the source of parity violations in these other payment systems. Inconsistent standards and reporting requirements are also problematic for payers, who are subject to different rules under different payment systems. **Consistent non-discriminatory coverage standards across insurance types will help consumers, payers, and regulators, both in Medicare and in Medicaid and commercial insurance**.

Prevent Cost-Shifting: Individuals who are dually eligible for both Medicare and Medicaid have among the highest rates of SUD and MH. Medicare's failure to cover SUD and MH benefits at parity means that costs for these individuals get shifted to states and other parts of the federal government. Individuals who have only Medicare, or even those with supplemental private insurance, face unaffordable out-of-pocket costs for their treatment when it is not reimbursed by Medicare. **Covering SUD and MH benefits at parity in Medicare would protect states and individuals from these inappropriate and unaffordable costs**.

Applying the Parity Act to Medicare will help us achieve non-discriminatory access to SUD and MH benefits for all.

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