

Modernize Medicare to Treat Substance Use Disorders: *A Roadmap for Reform*

THE NEED TO MODERNIZE MEDICARE

A significant number of Medicare beneficiaries need SUD treatment, but [Medicare does not cover essential SUD benefits or services](#). Approximately 1.7 million Medicare beneficiaries report having a SUD, yet only 11% received any SUD treatment in the past year (6% for beneficiaries over age 65, and 17% for those with long-term disabilities under 65).¹ Among those who did not get SUD treatment, 38% of Medicare beneficiaries over age 65 (and 28% of those under 65) reported financial barriers – including insurance not covering treatment – as a reason. Furthermore, [opioid overdose deaths and hospitalizations have continued to rise among older adults](#), even before COVID-19, and those rates are only expected to get worse. More people are seeking SUD and mental health² services as a result of stressors from the pandemic, but [these services have become less available](#) as COVID-19 exacerbated the behavioral health workforce shortages across the country.

Antiquated Reimbursement System

Medicare's coverage and reimbursement policies have historically focused on a “medical model” that prioritizes physician and hospital care over community- and team-based care. Generally, [SUD treatment is not integrated into mainstream medical care](#), and thus it is not routinely delivered in those settings or by the same providers. To address the unmet SUD treatment needs of Medicare beneficiaries, we cannot make incremental changes to an incomplete model of care. We must modernize Medicare by authorizing coverage, ensuring availability, and providing adequate payment for the missing services in the SUD continuum of care and team-based, authorizing community-based SUD providers and settings, supporting integration of SUD care in current medical settings, and requiring comparable coverage for SUD and mental health benefits and medical benefits.

Discriminatory Coverage

Because Medicare is not subject to the Mental Health Parity and Addiction Equity Act, the program imposes a wide range of treatment limitations to SUD and mental health services to a greater degree than those applied to medical/surgical services. The full scope of SUD and mental health benefits are not available to Medicare beneficiaries. There are no standardized medical necessity criteria for SUD and mental health services, and no requirements that there be an adequate network of providers in Medicare Advantage Plans. Medicare Advantage and Part D Plans impose burdensome and unnecessary prior authorization requirements, step therapy or “fail first” policies, and dosage limitations that prevent beneficiaries from getting timely access to appropriate services and medications for opioid use disorder.

Health Disparities

[Racism is a social determinant of health](#), and Black, Indigenous, and people of color (BIPOC) are making up increasing segments of the Medicare population. Presently, the portion of Black and Hispanic Medicare beneficiaries with SUDs (12% and 6% respectively) is consistent with the overall portions of Black and Hispanic Medicare beneficiaries, but these beneficiaries have [more problems accessing medical care and poorer health outcomes](#) than white beneficiaries. There has been a significant increase in [opioid-related overdoses among Black and Indigenous Americans](#), and they have the highest rates of opioid-related fatalities. Black and Hispanic Medicare beneficiaries are [less likely to have private supplemental insurance](#) than white beneficiaries, which is

¹ Parish, W. J., Mark, T. L., Weber, E., & Steinberg, D. (2021). Substance use disorders among Medicare beneficiaries: Insights from analysis of the National Survey of Drug Use and Health. *Working paper*.

² There are many additional barriers to mental health care in Medicare that we hope to resolve, though are not fully discussed in this roadmap.

especially important for accessing SUD treatment given Medicare's gaps in coverage. [Half of Black and Hispanic Medicare beneficiaries are enrolled in Medicare Advantage Plans](#), compared to 36% of white beneficiaries, which impose more limitations on access to SUD treatment than traditional Medicare. [BIPOC individuals are more likely to be penalized or incarcerated for drug-related offenses](#), and Medicare has an unnecessarily broad exclusion that prevents people on bail or parole from getting Medicare coverage in the community.

As we look to modernize – and potentially expand – Medicare, the systemic injustices that have plagued our health care system for far too long cannot be reinforced. These health disparities can be reduced by increasing access to the full scope of SUD treatment and actively ensuring availability to a wider range of culturally and linguistically effective practitioners who can deliver equitable, compassionate, anti-racist, and trauma-informed care, while eliminating barriers that disproportionately affect BIPOC beneficiaries.

MEDICARE'S COVERAGE GAPS

Medicare's coverage of SUD treatment is strikingly limited and out of sync with the modern system of care delivery. This contributes to over 1.5 million Medicare beneficiaries not getting the treatment they need, resulting in unnecessary hospitalizations and deaths. The most significant gaps in Medicare's coverage of SUD are:

- **Missing Services:** Medicare covers the least intensive and most intensive types of treatment but fails to cover intermediate levels of care. This bookended approach is inconsistent with the American Society of Addiction Medicine (ASAM) Criteria, which classifies SUD 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), but it lacks coverage for intensive outpatient/partial hospitalization services and residential services (ASAM Levels 2 and 3). These intermediate levels of SUD care are often used as a step down for patients who no longer need to be hospitalized but cannot be discharged safely into their communities, or as a step up for those who need more intensive services and supports. 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.
- **Missing Settings:** With the exception of opioid treatment programs, Medicare fails to cover community-based SUD treatment facilities that are not affiliated with a hospital system. These settings tend to offer multiple services on the ASAM continuum to facilitate appropriate care. Importantly, they deliver more of the intermediate and intensive levels of care than the currently covered Medicare settings. While Medicaid programs and private insurance typically cover these settings, beneficiaries lose access to treatment and trusted providers when they become eligible for Medicare unless they remain eligible and enrolled in another plan.
- **Missing Providers:** Medicare fails to cover many of the practitioners who treat patients with SUDs, including licensed professional counselors, certified alcohol and drug counselors, and peer support specialists. While Medicare covers psychiatrists, psychologists, and licensed clinical social workers, these providers have low participation rates in Medicare and have [among the highest opt-out rates of all practitioners in the program](#).
- **Lack of Parity/Anti-Discrimination Protections:** Unlike most Medicaid and private insurance plans, Medicare is not subject to the Mental Health Parity and Addiction Equity Act, the anti-discrimination law that requires insurers to cover SUD and mental health care at the same level as other medical or surgical care. As a result, Medicare beneficiaries with SUDs and mental health conditions can be – and are – subject to discriminatory financial and other treatment limitations.

RECOMMENDATIONS TO STRENGTHEN MEDICARE

Congress and the Centers for Medicare and Medicaid Services must modernize Medicare to deliver evidence-based SUD care to all beneficiaries using their respective authority. Medicare must cover the full SUD continuum of care, authorize the full range of addiction practitioners and treatment facilities, and be subject to the Parity Act.

Congressional Actions

Congress must take the following actions to improve access to SUD treatment in Medicare:

- **Authorize the Full Continuum of SUD Services**
 - *ASAM Levels of Care:* Congress should authorize delivery of and reimbursement for all [ASAM levels of care](#) that are currently not available, including intensive outpatient programs, partial hospitalization programs for individuals with SUDs, and all levels of residential treatment.
 - *Crisis Services:* Congress should authorize delivery of and reimbursement for [crisis services that meet the holistic needs of people with SUDs](#), including mobile crisis team services and crisis stabilization services. Access to affordable and comprehensive crisis services in the community is necessary to implement the new 988 suicide prevention helpline and save lives. These services must focus on recovery-oriented care, incorporate a significant role for peers, and utilize community-based partnerships to [divert people in crisis away from law enforcement](#).
 - *Contingency Management:* Congress should authorize delivery of and reimbursement for contingency management services, with appropriate guardrails to ensure equity, for the treatment of [methamphetamine use disorder](#) and [other SUDs](#) consistent with evidence-based practices.
- **Authorize Community-Based Settings Where SUD Care is Delivered:** Congress should authorize delivery of and reimbursement for community-based SUD treatment facilities, in the same way it covers community mental health clinics and other similar treatment settings.
- **Authorize and Appropriately Reimburse the Full Range of SUD Practitioners:** Congress should authorize delivery of and reimbursement for SUD services by Licensed Professional Counselors, Certified Alcohol and Drug Counselors, and Peer Support Specialists. Congress should also eliminate the current reimbursement percentage decrease for licensed clinical social workers, identify a fair reimbursement rate, and ensure that all SUD practitioners can be reimbursed for the range of services they provide.
- **Apply the Mental Health Parity and Addiction Equity Act to Medicare:** Congress should extend the Parity Act to Medicare in the same way it applies to most Medicaid and private insurance plans. Both traditional Medicare and Medicare Advantage plans must be prohibited from imposing discriminatory quantitative or non-quantitative treatment limitations for SUD or mental health care. Some of the most problematic limitations include discriminatory reimbursement rate setting practices, inadequate networks, and burdensome utilization management practices such as prior authorizations and quantity limits for services and prescription drugs.
- **Eliminate the 190-Day Lifetime Limit for Inpatient Psychiatric Care:** Congress should eliminate the discriminatory limit that prevents patients from receiving inpatient psychiatric care for more than 190 days over their lifetime, when such a limit does not apply to medical conditions.

Regulatory & Sub-regulatory Actions

The Centers for Medicare & Medicaid Services (CMS) must take the following actions to improve access to SUD treatment in Medicare:

- **Require Use of Standardized, Evidence-Based Medical Necessity Criteria:** CMS should require traditional Medicare and Medicare Advantage Plans to use [specific criteria and level of care assessment tools to determine medical necessity for SUD treatment](#). These medical necessity criteria should reflect generally accepted standards of care, such as the ASAM Criteria.
- **Establish Reimbursement for ASAM Levels of Care:** With coverage of all ASAM levels of care, CMS should develop reimbursement models for intensive outpatient programs, partial hospitalization programs, and residential treatment for SUD that cover the full cost of services to promote provider participation in Medicare and increase access to treatment. There should be add-on codes for additional services that can be delivered in all medical settings to reflect the complexity of the patient population and to enable withdrawal management in different levels of care.
- **Eliminate Discriminatory Utilization Management Practices:** CMS should promulgate rules and issue guidance to ensure that medical necessity determinations and level of care placements are made by the treating providers, not the insurer. To do so, CMS should prohibit Medicare Advantage and Part D Plans from imposing burdensome and unnecessary utilization management practices such as [prior authorization](#), step therapy, and quantity limits (including dosage limits for buprenorphine).
- **Eliminate Discriminatory Reimbursement Rate Setting:** CMS should require all Medicare Advantage Plans to reimburse SUD and mental health practitioners at rates that are comparable to those paid to practitioners of medical services and demonstrate compliance with non-discrimination standards.
- **Make Telehealth Flexibilities Permanent:** CMS should authorize audio-only telehealth for all SUD services delivered to Medicare beneficiaries in their homes, as it has proposed for opioid treatment programs (OTPs) and mental health services. CMS should review the telehealth-approved services and providers to ensure that beneficiaries have meaningful access to SUD treatment via telehealth as well as in-person services, as required by the SUPPORT Act and consistent with patient choice for care delivery.
- **Require Network Adequacy Standards & Reporting for SUD Providers:** CMS should require Medicare Advantage Plans to maintain adequate networks of SUD providers, including OTPs, by meeting quantitative metrics and report annual compliance. CMS should also collect and report out demographic data on providers to ensure that there are adequate networks of racially diverse and culturally and linguistically effective SUD providers for the increasingly diverse Medicare population.
- **Eliminate the Custody Exclusion for Beneficiaries in the Community:** CMS should issue guidance to ensure that individuals who are eligible for Medicare while on parole, probation, bail, or supervised release are not barred from coverage under the custody exclusion. [CMS removed a similar restriction for Medicaid in 2016](#) and should do so for Medicare to eliminate a significant barrier to care for individuals who are no longer incarcerated and would only be served in community-based care.

Modernizing Medicare will meet the needs of people with SUDs, eliminate discriminatory treatment practices, and save lives.

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