

**Medicare’s Expanded Coverage of Substance Use Disorder Treatment:
Important Progress and Recommendations to Fill Remaining Gaps**

The Legal Action Center launched the Medicare Addiction Parity Project ([MAPP](#)) in 2021 to address significant [gaps](#) in Medicare’s coverage of substance use disorder treatment. Improving this coverage is vital, as approximately 5.7 million Medicare beneficiaries (9%) have a substance use disorder, though less than 1 in 4 receive treatment. Tragically, the rate of overdose deaths among adults ages 65 and older has [quadrupled](#) over the past two decades, and Black men over the age of 65 are [7 times](#) more likely to die from an overdose than their white peers.

Since 2021, Congress and the Centers for Medicare and Medicaid Services (CMS) have adopted coverage and access reforms that will make treatment more affordable and accessible to Medicare beneficiaries who have a substance use disorder. These changes, as well as other reforms most recently [highlighted](#) by the Department of Health and Human Services Office of the Inspector General, are needed to address the staggeringly limited access to services, medications, and providers to treat substance use disorders for Medicare beneficiaries.

CLOSING COVERAGE GAPS

Until recently, Medicare covered only the least and most intensive levels of care for substance use disorder treatment, forcing many beneficiaries to forgo needed treatment or wait until their conditions became acute until they could get care. Medicare also did not cover the full range of the addiction provider workforce nor all the community-based settings in which treatment is delivered. Unlike Medicaid and commercial insurance, Medicare is not subject to the Mental Health Parity and Addiction Equity Act, the civil rights law that protects individuals with mental health and substance use disorders from discriminatory insurance practices. Taken together, many individuals have lost access to substance use disorder care when they transitioned from private or public insurance to Medicare.

As a result of the Consolidated Appropriations Act of 2023, Medicare beneficiaries have coverage of new services in the substance use disorder care continuum and a critical pool of providers may now deliver treatment. CMS strengthened these new benefits by addressing service delivery standards that are unique to substance use disorder treatment in its implementing regulations.

New Substance Use Disorder Treatment Coverage in Medicare			
	Previous Gaps	Progress	Next Steps
Services	Medicare essentially covered the least intensive	The Consolidated Appropriations Act of 2023 (CAA) authorized coverage of intensive outpatient (IOP) services in certain settings. CMS’s	Congress must authorize coverage of residential SUD treatment.

	(outpatient) and most intensive (inpatient) levels of care for SUD treatment, with some coverage of partial hospitalization services.	implementing regulations in the CY24 Outpatient Prospective Payment System authorized coverage of IOP in opioid treatment programs, and CMS further clarified that both IOP and partial hospitalization (PHP) services are available to beneficiaries with SUDs, as of 2024. Congress also authorized coverage of mobile crisis psychotherapy.	Congress must also authorize coverage of the full continuum of SUD and mental health crisis care.
Providers	Medicare covered psychiatrists, psychologists, and clinical social workers to treat beneficiaries with SUDs.	The 2023 CAA, along with CMS’s implementing regulations in the CY24 Physician Fee Schedule, authorized coverage of master’s level mental health and addiction counselors and marriage and family therapists; peer support specialists and community health workers can deliver services addressing social determinants of health under supervision as of 2024.	Congress and CMS must authorize coverage and/or develop coding and payment to ensure non-master’s level addiction counselors and peer support specialists can deliver services to beneficiaries.
Facilities	Medicare does not cover community-based SUD treatment facilities other than opioid treatment programs.		Congress must authorize coverage of community-based SUD treatment facilities to deliver the full continuum of SUD services.
Parity	Medicare is not subject to the Mental Health Parity and Addiction Equity Act, unlike commercial health plans and most Medicaid plans.	In the 2023 CAA, Congress required the Government Accountability Office to conduct a study on the disparities in access to mental health and SUD care in both traditional Medicare and Medicare Advantage.	Congress must apply the Parity Act to all parts of Medicare.

CMS has bolstered these coverage expansions with a series of additional regulatory changes to improve access to substance use disorder treatment in both traditional Medicare and Medicare

Advantage. Federal regulators are tackling the two most significant barriers to access: low reimbursement rates and inappropriate utilization review requirements. Low reimbursement rates make it impossible for many providers who deliver substance use disorder services to accept Medicare beneficiaries. The low reimbursement rates have been compounded by no meaningful enforcement of Medicare Advantage plans’ requirements to maintain adequate networks of providers to make treatment available and accessible to enrollees. Moreover, Medicare Advantage plans have used proprietary coverage criteria and other utilization management practices to delay and deny treatment. CMS has begun to address these access barriers.

Improvements to Accessing Substance Use Disorder Treatment in Medicare		
	Progress	Next Steps
Reimbursement Rates	Over the past several years, CMS increased reimbursement rates for a number of SUD and MH services, including the opioid treatment program benefit, the office-based SUD treatment and counseling benefit, psychotherapy codes, and behavioral health integration.	Congress must increase the reimbursement rates for clinical social workers, mental health and addiction counselors, and marriage and family therapists to be at least comparable to that for nonphysician medical practitioners.
Network Adequacy: Appointment Wait Time Standards	In 2023, CMS established appointment wait time network adequacy standards for MH and SUD treatment in Medicare Advantage plans: 30 business days for routine care.	CMS must align appointment wait time standards with those in commercial health plans and Medicaid managed care plans: 10 business days for routine care.
Network Adequacy: Geographic Standards	In 2023 and 2024, CMS established geographic time and distance network adequacy standards for clinical psychologists, clinical social workers, and “outpatient behavioral health” in Medicare Advantage plans.	CMS must align geographic time and distance standards with those in commercial health plans. CMS must also establish and track network adequacy standards separately for MH and SUD providers, rather than collapsing them into one category.
Utilization Review: Standardized Coverage Criteria	In 2023, CMS required Medicare Advantage plans to use the same clinical criteria as traditional Medicare for coverage decisions, and to use nationally recognized	Congress and CMS must review and update the coverage criteria for traditional Medicare and ensure they align with the ASAM Criteria and effectively meet the

	clinical standards when no traditional Medicare criteria exist.	needs of different sub-populations.
Utilization Review: Prior Authorization Reform	In 2023 and 2024, CMS required Medicare Advantage plans to limit their use of prior authorizations, and to respond to prior authorization requests within a standardized time frame across all types of insurance.	Congress and CMS should prohibit all Medicare plans from imposing prior authorization on medications for opioid use disorders and remove other barriers to SUD treatment, such as cost-sharing, step therapy, and concurrent and retrospective review.

RECOMMENDATIONS TO FILL REMAINING GAPS

Even with these significant legislative and regulatory reforms, recent research has demonstrated that much more needs to be done to improve access to substance use disorder treatment for Medicare beneficiaries.

1. Improve Coverage of Substance Use Disorder Medications & Services

A. Remove Barriers to Medications for Opioid Use Disorder

Congress and CMS must work together to improve access to medications for opioid use disorder (MOUD), the evidence-based standard of care for this condition. A [report](#) from the Department of Health and Human Services Office of the Inspector General highlights the dismal rates of MOUD use and disparate access by beneficiaries of color:

- Of the 1.1 million Medicare beneficiaries with an opioid use disorder in 2022, only 18% received MOUD.
- Approximately 19% of white beneficiaries with an opioid use disorder received MOUD, compared to 15% of Black beneficiaries, 15% of Hispanic beneficiaries, and 11% of Asian/Pacific Islander beneficiaries.
- Black and Hispanic beneficiaries were more likely to receive methadone (7%) - which is only available at opioid treatment programs - than white beneficiaries (5%) and Asian/Pacific Islander (4%) beneficiaries.
- Medicare beneficiaries without financial assistance for their Part D drug coverage were almost three times less likely to receive MOUD than those with financial assistance (9% compared to 26%).

These findings demonstrate that cost and access to providers remain critical barriers to evidence-based substance use disorder care, particularly for Black and brown beneficiaries. While Congress eliminated cost-sharing for opioid treatment programs in traditional Medicare, Medicare Advantage plans can still impose cost-sharing, as well as utilization management practices. A recent [study](#) found that 57% of Medicare Advantage beneficiaries were in plans

that required a co-pay for opioid treatment program-based MOUD, and 85% of Medicare Advantage beneficiaries were in plans requiring prior authorization. While fewer plans require prior authorization for buprenorphine, both traditional Medicare and Medicare Advantage still have cost-sharing for MOUD – and any additional services – in office-based settings.

RECOMMENDATIONS

- Congress should remove cost-sharing for office-based substance use disorder treatment and medications.
- CMS should prohibit Medicare Advantage plans from imposing cost-sharing for opioid treatment programs and prior authorization requirements for MOUD.
- CMS should also develop discrete network adequacy standards for prescribers of MOUD.

B. Authorize Coverage of Residential Substance Use Disorder Treatment

While Congress and CMS have now established Medicare coverage for most levels of care identified by the American Society of Addiction Medicine (ASAM), the major outstanding gap in the continuum of care is residential substance use disorder treatment. Health insurance must cover the full continuum of care so that people can get the most effective treatment for their condition – both when they decide to enter treatment and when they need to step down or step up for more or less intensive levels of care.

RECOMMENDATION

Congress should authorize Medicare coverage for residential substance use disorder treatment, consistent with the ASAM Criteria.

C. Authorize Coverage of Mobile Crisis Teams

Congress authorized coverage of mobile crisis psychotherapy in the 2023 CCA with an enhanced reimbursement rate and with direction to CMS to educate the community on how peers can help deliver crisis services. Peers play a critical role in mobile crisis teams, in which mental health or substance use disorder professionals, rather than law enforcement, are dispatched to the person experiencing a crisis. These teams provide in-person de-escalation and support to help reduce unnecessary law enforcement involvement, as well as emergency department visits and hospitalizations, and provide more timely linkages to mental health and substance use disorder care. However, Medicare does not currently cover mobile crisis teams or the full range

of services they provide. Nearly [three-quarters](#) of state Medicaid programs do cover mobile crisis teams. Reducing interactions between the person in crisis and law enforcement is vital because such encounters often lead to punitive responses and the criminalization of these conditions, rather than treatment, especially for Black and brown individuals. In fact, as the new 988 Suicide and Crisis Helpline has rolled out, the most common concern ([41%](#)) that people have shared would prevent them from calling is the fear that law enforcement would respond.

RECOMMENDATION

Congress should authorize Medicare coverage of mobile crisis teams to maximize the efficacy of 988, help get beneficiaries the full range of crisis support they need, and limit unnecessary involvement with the criminal legal system.

2. Enhance the Medicare Workforce of Substance Use Disorder Providers and Facilities

A. Authorize Coverage of Community-Based Substance Use Disorder Treatment Facilities

Although Medicare now covers intensive outpatient treatment, this service – as well as other outpatient and intermediate levels of care – is not meaningfully available because the community-based facilities in which SUD care is most often delivered are not Medicare covered settings. Licensed substance use disorder treatment facilities are no different from other community-based settings, including community mental health centers (CMHCs) and opioid treatment programs, and coverage of this facility type would expand the pool of addiction providers who can treat Medicare beneficiaries. Mental health conditions and substance use disorders are not interchangeable, and many states prevent mental health practitioners from treating patients with substance use disorder diagnoses.

RECOMMENDATION

Congress should authorize Medicare coverage for community-based substance use disorder treatment facilities to deliver the full continuum of evidence-based substance use disorder treatment services.

B. Expand the Workforce to Peer Support Specialists and Non-Master’s Level Clinicians

The new coverage of services to address the social determinants of health for Medicare beneficiaries is a significant step forward for incorporating peer support specialists into the Medicare workforce, but it falls short of meeting their full potential. Peers have first-hand experience navigating the treatment system and recovery, and they can provide mentoring, coaching, connections to community-based supports and resources, goal setting, advocacy, skill development, and encouragement of treatment initiation, adherence, and long-term recovery. Beyond supporting a subset of providers through these new codes, peers could be more meaningfully incorporated into the full substance use disorder care continuum and integrated care settings for Medicare beneficiaries.

Furthermore, CMS’s model to expand coverage to peers can be replicated to improve access to non-master’s level addiction counselors. These practitioners deliver critically needed substance use disorder counseling under general supervision in a wide range of settings and bolster the addiction treatment workforce. Recognizing that states have their own licensure and certification requirements for addiction counselors, CMS should develop codes that enable all of these counselors to practice within their scope to treat Medicare beneficiaries.

RECOMMENDATIONS

- Congress and CMS should work together to ensure that peers can deliver the full range of recovery supports and services – and in the full range of settings – that they are trained and certified to provide under state law.
- Absent statutory authority to bill Medicare directly, CMS should develop coding and payment to cover the full scope of services non-master’s level addiction counselors are licensed or certified to deliver under state law and ensure they are available to expand the provider pool for Medicare beneficiaries.

C. Increase Reimbursement Rates

Many substance use disorder and mental health providers are not accepting insurance – including Medicare – because of the low reimbursement rates and administrative burden. The Department of Health and Human Services Office of the Inspector General recently [found](#) abysmal rates of provider participation in Medicare:

- Only about 1 in 3 mental health and substance use disorder providers are actively participating in Medicare (29% in traditional Medicare and 33% in Medicare Advantage).
- There are fewer than 5 active mental health or substance use disorder providers per 1,000 enrollees (2.9 in traditional Medicare and 4.7 in Medicare Advantage), and fewer

than 2 who could prescribe medication (0.8 in traditional Medicare and 1.4 in Medicare Advantage).

- Rural counties have less than half of the number of active mental health or substance use disorder providers as urban counties.
- Less than 5% of Medicare beneficiaries receive treatment from a mental health or substance use disorder provider (4% in traditional Medicare and 3% in Medicare Advantage).

While CMS made nominal improvements to the reimbursement rates for several substance use disorder and mental health services, the pervasive [undervaluing](#) of treatment for these conditions requires a more systemic examination, as noted by the Office of the Inspector General. Treatment should not only be reserved for people who can afford to pay out of pocket.

RECOMMENDATIONS

- Congress should also increase the reimbursement rates for clinical social workers, mental health and addiction counselors, and marriage and family therapists (75% of the Physician Fee Schedule) to, at a minimum, align with the reimbursement rates for non-physician medical practitioners (85% of the Physician Fee Schedule).
- Congress and CMS should work together with the substance use disorder and mental health provider community to identify fair reimbursement rates that cover the cost of care and incentivize providers to join networks.

3. Improve Medicare Advantage Network Adequacy Standards

Far too few substance use disorder and mental health providers participate in the Medicare program. As the Office of the Inspector General [report](#) noted, CMS can strengthen network adequacy standards to “drive an increase” in provider participation in Medicare Advantage. Specific and separate tracking of substance use disorder and mental health providers is required to fully assess the gaps in access to care for each condition. As noted above, mental health counselors and substance use disorder counselors have separate licensing requirements and scopes of practice in many states, and they may not be able to see patients with these conditions interchangeably nor have the training to do so. Additionally, not all providers who can prescribe mental health medications may be authorized or willing to prescribe all MOUD.

CMS’s new network adequacy standard for “outpatient behavioral health,” as well as those for psychiatrists, psychologists, and clinical social workers, will not provide sufficiently granular data to guide oversight of network participation of substance use disorder providers. This new category encompasses mental health counselors, addiction counselors, marriage and family therapists, opioid treatment programs, and more. However, a Medicare Advantage plan could

effectively meet this standard by contracting only with mental health counselors, and thereby have no opioid treatment programs or addiction counselors in its network.

RECOMMENDATION

Ideally, CMS should create a separate category for prescribers of medications for opioid use disorder to promote greater access to these lifesaving medications, consistent with the Office of the Inspector General recommendations. At a minimum, CMS should establish separate network adequacy categories for outpatient mental health care and outpatient substance use disorder care.

The Office of the Inspector General also recommended that CMS align the network adequacy standards for Medicare Advantage plans with those in other health care financing systems. The geographic time and distance standards for outpatient behavioral health in Medicare Advantage are almost twice those established for commercial insurance plans, and the appointment wait time standard is three times as long. CMS has recently finalized new appointment wait time network adequacy standards for Medicaid managed care plans that are consistent with those for commercial insurance plans, and Medicare Advantage beneficiaries should not be subject to weaker protections.

RECOMMENDATION

CMS should align the Medicare Advantage network adequacy standards with those established for commercial insurance plans and Medicaid managed care plans.

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

For the third year in a row, the [Biden Administration](#) has called for the application of the Parity Act to the Medicare program. Many of the gaps and barriers described above could be addressed if Medicare were subject to non-discrimination standards.

Limitations on Scope of Services: The Parity Act requires insurers that cover any substance use disorder or mental health benefits to provide coverage of those benefits in all classifications (inpatient, outpatient, emergency, and prescription drugs) in which medical services are provided. As in private health plans, to the extent Medicare covers skilled nursing facilities and residential rehabilitation for medical conditions, the Parity Act would bar Medicare from continuing to exclude residential substance use disorder treatment when these services are reasonable and necessary. Since Medicare covers ambulances and emergency medical teams

for physical crises, Medicare would also need to cover mobile crisis teams for substance use disorder and mental health crises if it were subject to the Parity Act.

Limitations on Providers: The Parity Act also prohibits insurers from imposing discriminatory restrictions on the care settings or providers who can deliver services. By preventing Medicare beneficiaries from accessing covered benefits from community-based substance use disorder treatment facilities and from non-master’s level addiction counselors, Medicare has limited access to outpatient substance use disorder treatment in a way that may be more restrictive than for physical outpatient treatment, which would be impermissible under the Parity Act.

Network Composition: The Parity Act further requires insurers to use the same factors when building and maintaining their networks of medical and surgical providers as it uses for substance use disorder and mental health providers, including reimbursement rates and standards for network adequacy. Medicare’s systemic undervaluing of substance use disorder and mental health services, including the greater percentage reduction in reimbursement for social workers and counselors, would violate the Parity Act. Parity also requires separate comparisons of substance use disorder care and mental health care to medical care, which would require network adequacy standards to separately track and measure these providers if the Parity Act applied to Medicare.

Utilization Management: The Parity Act also prohibits insurers from using utilization management standards like prior authorizations more restrictively for substance use disorder and mental health services than for medical and surgical services. The overuse of this practice for MOUD in Medicare Advantage plans, especially when it is not consistent with generally accepted standards of care, would likely violate the Parity Act. Furthermore, insofar as Medicare coverage criteria align with generally accepted standards of care as developed by professional medical societies for medical and surgical benefits, the Parity Act would require Medicare coverage criteria for substance use disorder treatment to align with ASAM Criteria.

While statutory revisions would be required to fully address some of these barriers to care, [applying the Parity Act to Medicare](#) will still enable significant improvements in access and give policymakers an effective tool to root out discrimination in the program. Approximately 9% of Medicare beneficiaries have a substance use disorder, but less than one in four of them receive treatment (NSDUH 2022). [One in four](#) Medicare beneficiaries have a mental health condition, but less than half of them receive treatment. Congress must apply the Mental Health Parity and Addiction Equity Act to Medicare to enable older adults and people with disabilities to get the treatment they need and deserve.

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