

**Two Plans Are Not Always Better Than One:  
*Barriers to Substance Use Disorder Treatment for  
Dual-Eligible Individuals***

Almost 1.5 million individuals who are eligible for both Medicare and Medicaid – dual-eligible individuals – have a substance use disorder diagnosis, and most have far more complex and costly health conditions than individuals who qualify for Medicare alone. Despite progress in recent years, gaps in Medicare’s coverage of substance use disorder treatment must be addressed to ensure dual-eligible individuals get the care they need. While Medicaid helps cover some of the missing services and providers in and costs associated with Medicare coverage, these individuals still face unique barriers to care. With new and expanded coverage of substance use disorder benefits beginning in 2024, policymakers must take steps to fix the problems that dual-eligible individuals face.

This issue brief identifies the unique barriers to substance use disorder treatment that dual-eligible individuals face and measures for providing more seamless access to care. Specifically, we recommend policymakers:

1. Incentivize and promote integration of Medicare and Medicaid benefits, with a focus on comprehensive care for substance use disorders.
2. Incentivize providers to equitably treat dual-eligible individuals with substance use disorders, particularly Black and brown individuals, and reduce beneficiary cost sharing.
3. Streamline and strengthen processes for accessing benefits for substance use disorder treatment.
4. Apply the Mental Health Parity and Addiction Equity Act to all parts of Medicare.
5. Improve enforcement of the Mental Health Parity and Addiction Equity Act in Medicaid.

These unique barriers and recommendations are synthesized in a chart at the conclusion of this report. While this issue brief does not address specific models of care, it identifies the baseline requirements that both health care financing systems and plans should include to meet the needs of people with substance use disorders.

## **BACKGROUND ON DUAL-ELIGIBLE BENEFICIARIES**

Approximately 13.4 million individuals have both Medicare and Medicaid coverage for their health insurance: “dual-eligible” individuals.<sup>1</sup> Medicare covers individuals who are ages 65 and older, as well as people with chronic disabilities. These individuals may also qualify for Medicaid if they have a low income or, in fewer cases, as a result of their disability status or health care needs.

Medicare is the primary payer for dual-eligible individuals, but their Medicaid coverage – which is often more comprehensive than Medicare – can fill in some of the gaps in Medicare. Most dual-eligible individuals qualify for the benefits and services that are offered through both the Medicare and Medicaid insurance programs, and their Medicaid coverage also pays for their Medicare [cost sharing](#), which includes premiums, deductibles, and co-pays and co-insurance. About one in four dual-eligible individuals receive partial benefits,<sup>2</sup> for which they get financial assistance from Medicaid to cover some of the costs of Medicare (such as the monthly premium and cost sharing), but they do not qualify for the additional benefits and services from Medicaid.

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Dual enrollment status has been identified as the [most powerful predictor](#) of poor outcomes on health care quality measures, which may occur because of “higher levels of medical risk, worse living environments, greater challenges in adherence and lifestyle, and/or bias or discrimination.” Dual-eligible individuals account for approximately [one-third](#) of both Medicare and Medicaid spending, despite comprising only 17% of the traditional Medicare population and 14% of the Medicaid population.

### Key statistics on dual-eligible individuals:<sup>3</sup>

- Approximately half of dual-eligible individuals are from communities of color – 22% Black, 20% Hispanic, and 9% other racial/ethnic groups – compared to only 20% of Medicare-only individuals.
- The majority of dual-eligible individuals have incomes below the federal poverty line, and almost 9 in 10 dual-eligible individuals live on incomes less than \$20,000 per year.
- Dual-eligible individuals are more likely than their Medicare-only counterparts to report having poor or fair health status: 44% compared to 17%.
- Almost half of dual-eligible individuals have at least one limitation on their activities of daily living.
- More than a quarter of dual-eligible individuals have five or more chronic health conditions, and almost half have a mental health condition.
- More than one in ten dual-eligible individuals (11.2%) have a substance use disorder.<sup>4</sup>

## BARRIERS TO SUBSTANCE USE DISORDER TREATMENT

While some states have made progress integrating Medicare and Medicaid benefits into a single plan to coordinate care,<sup>5</sup> most dual-eligible beneficiaries are still receiving their care from both programs separately with little coordination. This forces dual-eligible individuals to navigate multiple sets of benefits, government agencies, providers, and, especially in the case of managed care, utilization management practices like prior authorization. This often leads to [fragmented care and poor health outcomes](#). As explained below, these barriers to care are often even worse for substance use disorder treatment than for other conditions.

### 1. Navigating Conflicting and Disparate Benefits under the Medicare and Medicaid Programs

Most state Medicaid plans offer substantially more comprehensive coverage of substance use disorder treatment than Medicare, although only twelve states cover the full continuum of care.<sup>6</sup> Over the past five years, Medicare’s coverage has been improving incrementally, with the coverage of opioid treatment programs (OTPs) in 2020 and intensive outpatient treatment (IOP) in 2024. However, Medicare still does not cover residential substance use disorder treatment. The other intermediate levels of substance use disorder care – IOP and partial hospitalization programs (PHP) – are not available to Medicare beneficiaries in community-based substance use disorder treatment facilities. While these facilities are certified by states and provide treatment to individuals with Medicaid coverage, they are neither recognized by Medicare nor authorized to bill Medicare for services. Medicare also has more stringent rules for a number of these services than Medicaid, many of which do not align with generally accepted standards of care, such as those in the American Society of Addiction Medicine (ASAM) Criteria.

Therefore, when dual-eligible beneficiaries need substance use disorder treatment, they are forced to navigate different benefit coverage and requirements across the two programs and may ultimately be at

risk of having to choose between paying for some care out-of-pocket or foregoing the treatment altogether. In such cases, two forms of health insurance are not necessarily better than just one.

The following chart identifies the differences in substance use disorder coverage and eligible providers in Medicare and Medicaid, mapped onto the ASAM Criteria.

Benefit	Medicare	Medicaid
<b>Outpatient Treatment (ASAM Level 1)</b>	Outpatient services can be delivered by psychiatrists, psychologists, and clinical social workers. As of 2024, services can also be delivered by master’s level mental health counselors (including professional counselors and addiction counselors) and marriage and family therapists. These providers must be enrolled in Medicare.	Outpatient services can be delivered by all of the practitioners authorized by Medicare, but they can also be delivered in freestanding substance use disorder (SUD) treatment facilities certified by the state. These providers must be enrolled in Medicaid.
<b>Intensive Outpatient Program (IOP) (ASAM Level 2.1)</b>	As of 2024, IOP can be delivered in specific settings, including hospital outpatient departments, community mental health centers, rural health clinics, federally qualified health centers, and opioid treatment programs (but only for beneficiaries with an opioid use disorder). A physician must certify the patient’s need for IOP and develop the plan of care.	At least 43 states and D.C. cover IOP in Medicaid. <sup>7</sup> IOP can be delivered in any of the settings authorized by Medicare, as well as community-based SUD treatment facilities certified by the state. Opioid treatment programs can also deliver IOP for individuals with other SUDs and mental health conditions. Non-physician practitioners, such as licensed professional counselors, may develop the plan of care.
<b>Partial Hospitalization Program (PHP) (ASAM Level 2.5)</b>	PHP can only be delivered in hospital outpatient departments or community mental health centers. A physician must certify the patient’s need for PHP and develop the plan of care. A physician must certify that a patient would otherwise need inpatient psychiatric treatment to receive PHP.	At least 33 states cover PHP in Medicaid. <sup>8</sup> PHP can be delivered in any of the settings authorized by Medicare, as well as community-based SUD treatment facilities certified by the state. Non-physician practitioners may develop the plan of care and there is no requirement that a patient would otherwise need inpatient psychiatric treatment.
<b>Residential Treatment (ASAM Level 3.1, 3.3, 3.5, and 3.7)</b>	Other than inpatient treatment in a hospital, Medicare does not cover residential substance use disorder treatment.	At least 38 states and D.C. cover at least one level of residential treatment in Medicaid. <sup>9</sup> Medicaid typically only covers residential treatment at facilities with 16 or fewer beds for non-elderly adults, although <a href="#">more than half of the states</a> have applied for or received a waiver to pay for this care in facilities with more beds.

<b>Inpatient Treatment (ASAM Level 4)</b>	Medicare covers inpatient treatment, with a 190-day lifetime limit on inpatient psychiatric treatment at specialty facilities, although there is no lifetime limit on inpatient medical treatment.	Nearly all states cover inpatient SUD treatment in Medicaid. There is no lifetime limit on inpatient treatment days.
<b>Crisis Services</b>	Other than coverage of crisis psychotherapy, including mobile crisis psychotherapy as of 2024, there is no coverage of mobile crisis teams or crisis stabilization facilities.	Although there is wide variation across states, <a href="#">nearly three-quarters of states</a> cover mobile crisis services and two-thirds cover crisis stabilization facilities.
<b>Peer Support Services</b>	Medicare does not explicitly cover peer support services, but starting in 2024, peers and other auxiliary personnel can help address social determinants of health through “incident to” billing.	As of 2019, <a href="#">38 states and DC</a> cover peer support services.

## 2. Finding Providers and Navigating Inadequate Networks

### a. Challenges Finding Medicare and Medicaid Providers and Billing Practices that Improperly Shift Costs to Dual-Eligible Individuals

Both Medicare and Medicaid require beneficiaries to receive care from providers who are enrolled in the respective programs. However, not all providers who are authorized by law to treat Medicare or Medicaid beneficiaries choose to enroll in one or both financing systems. A practitioner’s participation in one or both programs affects whether care is available and affordable to individuals, and substance use disorder and mental health professionals have among the highest rates of not participating in Medicare and Medicaid. Psychiatrists make up the [largest share](#) of active physicians who have opted out of Medicare, and [only 36% of psychiatrists](#) accept new Medicaid patients. This low rate of provider participation, particularly for substance use disorder and mental health providers, makes it more difficult for dual-eligible individuals to find providers who accept their insurance than for beneficiaries who are enrolled in only one of these programs.

Providers are often not familiar with how the two systems work together and may bill beneficiaries incorrectly. Even if a provider is enrolled in both Medicare and Medicaid, they may [erroneously charge](#) dual-eligible individuals a deductible and coinsurance, rather than bill Medicaid for these costs. Other providers may be enrolled only in Medicare, and therefore be unable to submit those reimbursement claims to the state Medicaid program or managed care organization. As a result, providers incorrectly bill dual-eligible individuals for these costs, and many of these patients simply pay the bills they receive, even though such billing is prohibited, or they forgo treatment. Even if a patient knows that they are being improperly billed, they may not have the time or energy to challenge the bills, especially if they are struggling with a substance use disorder. They may also be worried about the impact of challenging these bills on their health or their relationship with providers, particularly when the patient-provider relationship is such an integral part of the treatment and when the number of substance use disorder providers in Medicare is so low.

Many community-based providers are covered in Medicaid but not Medicare, such as community-based substance use disorder treatment facilities other than opioid treatment programs. Even with the option for Medicaid coverage, only about 62% of specialty substance use disorder treatment facilities reported

accepting Medicaid as of 2016, and some of those facilities may not be able to provide all levels of care to Medicaid recipients due to the lack of state Medicaid coverage for those services.<sup>10</sup> (See section 1.) Substance use disorder treatment facilities that offer more intensive levels of care, including PHP and residential treatment, have a lower rate of Medicaid participation than those with less intensive treatment.<sup>11</sup>

While dual-eligible beneficiaries who receive full Medicaid benefits should be able to receive services from participating providers, even if a provider is not authorized by Medicare, unique benefit coordination challenges often prevent individuals from getting such services reimbursed. Medicare must be billed and pay first for covered services. By law, Medicaid is the payor of last resort, and all other forms of insurance must be exhausted before Medicaid pays. Consequently, even if a service or setting is statutorily excluded under Medicare, the state Medicaid program may still require the provider to submit the claim to Medicare and receive a denial before it can be submitted to Medicaid.

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Providers find themselves in a catch-22 position in states that have not established a billing process to address the coverage mismatch. Providers and facilities that are not authorized to bill under Medicare do not have the ability to submit claims, and those that are authorized under Medicare may be confused about how to bill for services that are only covered by Medicaid. Providers may therefore deny treatment to dual-eligible individuals if they are not able to readily bill Medicaid for specific services. This means that, for example, dual-eligible individuals seeking IOP, PHP, or residential treatment from a community-based substance use disorder treatment facility may not be able to access this care even if they have full Medicaid benefits and their state Medicaid program covers this service and setting.

#### **b. Inadequate Medicare Advantage and Medicaid Managed Care Networks and Network Adequacy Standards for Substance Use Disorder Treatment**

Limited access to substance use disorder and mental health professionals is exacerbated for beneficiaries who are enrolled in Medicare Advantage and/or Medicaid managed care plans. Under these delivery systems, the beneficiary must see a provider who contracts with that specific plan, not just any provider who accepts Medicare or Medicaid. These networks tend to be incredibly narrow, as nearly [two-thirds](#) of Medicare Advantage plan directories contain fewer than 25% of the psychiatrists in the plan's service area, and only 40% in Medicaid managed care. The true rate of access is likely even worse, because plan directories notoriously contain significant inaccuracies. For example, a 2023 Senate Finance Committee secret shopper survey found that [more than 80%](#) of mental health providers who were listed in Medicare Advantage plans' directories were either unreachable, not accepting new patients, or not actually in-network. Committee staff were able to schedule an appointment only 18% of the time. Beneficiaries must not only find a provider who accepts their plan but must also secure an appointment with one of a limited number of network providers. This problem is compounded for dual-eligible beneficiaries, who have to find a provider that accepts both plans.

While Medicare Advantage plans are required to maintain an adequate network of providers of certain specialties, including psychiatry, there is no specific network adequacy requirement for substance use disorder providers.<sup>12</sup> Access standards may also differ across the two programs. In 2022, CMS established new appointment wait time standards, requiring enrollees in Medicare Advantage plans to have access to routine outpatient substance use disorder and mental health care within 30 business days.<sup>13</sup> In contrast, for Medicaid managed care, CMS has proposed that the maximum wait time for the

same services can be no more than 10 business days, which is consistent with the standards in place for qualified health plans on the individual marketplace.<sup>14</sup> These conflicting timelines will make it more difficult for dual-eligible individuals to know when they have a right to seek out-of-network care and to appeal denials.

### 3. Reimbursement Policies that Limit Access to Substance Use Disorder Treatment for Dual-Eligible Individuals

In addition to the billing problems described in section 2, unique reimbursement standards for services delivered to dual-eligible beneficiaries reduce total payment to providers at the point of service, making them less likely to serve this population. [Most state Medicaid programs have “lesser-of” policies](#) that limit Medicaid’s payments of Medicare cost sharing (deductible and coinsurance) when the state’s Medicaid program reimburses at a lower rate than Medicare.<sup>15</sup> In these situations, Medicaid would pay the lower of (a) the full Medicare cost-sharing amount that a provider would receive if the beneficiary had Medicare only and (b) the difference between the Medicaid fee schedule rate and the Medicare rate. As a result, substance use disorder and mental health [practitioners may be paid up to 20% less](#) for treating dual-eligible individuals than they would for treating Medicare-only beneficiaries.

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This policy is especially problematic for substance use disorder and mental health care because of low Medicaid reimbursement in many states. Medicaid reimbursement rates of psychiatry services are [substantially lower \(81%\)](#) than Medicare, with significant variation across states. [Similar disparities](#) exist for substance use disorder treatment, with more than 4-fold variation across states’ Medicaid reimbursement for opioid treatment program services and a national average of 56% of the Medicare rate.

Medicare’s reimbursement for substance use disorder and mental health providers is already discriminatorily lower than that for other medical conditions. Medicare is not subject to the Mental Health Parity and Addiction Equity Act which, among other things, requires comparable factors to be used when developing reimbursement practices for substance use disorder and mental health benefits as for medical/surgical benefits. Licensed clinical social workers (and, as of January 2024, professional counselors and marriage and family therapists) are paid at a lower rate than other non-physician practitioners based on a larger percentage discount (75% compared to 85%) of the base rate, which the Departments of Labor has determined to be a [parity violation](#) in private insurance.

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CMS has also recognized that the methodology for establishing Medicare rates results in a “systemic undervaluation of work estimates for behavioral health services” and that counseling services for substance use disorders and mental health conditions are among the services most affected by their existing methodology.<sup>16</sup> Accordingly, substance use disorder and mental health providers who treat Medicare beneficiaries are starting off

at a lower reimbursement baseline than medical providers, which translates to even lower reimbursement for those who treat dual-eligible individuals because of the “lesser-of” policies.

These policies are especially problematic for substance use disorder and mental health practitioners because of ongoing discriminatory rate-setting in Medicaid. Even though managed care and alternative benefit plans are required to comply with the Parity Act, [many states are failing to conduct reimbursement rate analyses](#) under this non-discrimination law to determine if their reimbursement practices are comparable for substance use disorder, mental health, and medical practitioners. Because states often use Medicare as a benchmark for setting their reimbursement rates in Medicaid, they are likely adopting these discriminatorily disparate rates for substance use disorder and mental health practitioners. As a result, the total payment that substance use disorder practitioners who treat dual-eligible individuals receive may be lower than what medical practitioners would receive, even for delivering the same or comparable services.

In addition, [current pay-for-performance strategies in Medicare](#) often effectively penalize providers in fee-for-service Medicare who treat patients who are at a higher risk for poor outcomes. As previously noted, dual-eligibility status is the most powerful predictor of poor outcomes, meaning that providers are more likely to have worse performance on quality measures and may be financially penalized for treating these individuals.

#### **4. Utilization Management Practices that Lead to Beneficiaries Delaying or Forgoing Care**

Dual-eligible individuals must also navigate two distinct systems of utilization management requirements when their care is not coordinated under an integrated health plan. Utilization management is the set of techniques and policies that health plans use to determine the appropriate level of care and manage health care costs. These requirements can include prior authorization, concurrent authorization, retrospective review, medical necessity criteria, benefit design, network tier design, drug tier design, referral protocols, step therapy or fail first policies, and more.<sup>17</sup> These policies delay and may interfere with treatment recommended by the treating providers, often resulting in significant administrative time and burden to get patients the care they need. However, the administrative burden and delay in initiating care is even more profound when providers must go through these processes for multiple plans – such as getting a prior authorization from both the Medicare Advantage plan and the Medicaid managed care organization or satisfying different requirements to demonstrate that the treatment is medically necessary or if a patient is required to attempt a different course of treatment first.

Providers, such as some opioid treatment programs, have reported that Medicare Advantage utilization management practices are so burdensome that they have withdrawn from the Medicare program altogether. Medicare Advantage plans have recently come under scrutiny for their excessive use of prior authorization practices to delay or deny care. A report from the Office of the Inspector General in 2022 found that [13% of Medicare Advantage plan denials of prior authorization requests](#) actually met the Medicare coverage rules, meaning that those services would have been covered if the beneficiaries were enrolled in traditional Medicare. Such denials prevent beneficiaries from getting the care they need or lead to significant delays as beneficiaries are forced to appeal.

#### **5. Problematic Denial Practices and Challenges with Navigating Multiple Appeals Processes**

Medicare and Medicaid also have two separate appeals processes that dual-eligible beneficiaries must navigate when their prescribed treatment is denied. The different coverage policies between the two systems compound this problem, because [Medicaid payers may incorrectly deny coverage](#) when they do not understand Medicare policies and rules and how these benefits must be coordinated with Medicaid.

The [expansion of substance use disorder coverage in Medicare starting in 2024](#) will likely create additional challenges for beneficiaries who need IOP or care from addiction counselors.

Benefit denials and appeal processes are difficult to navigate. Denial notices often lack the level of detail needed to understand the reason for denial and to substantiate their claim for services or clear information on where to file an appeal. Additionally, people who are denied substance use disorder treatment often are not able to appeal a denial within the required timeframe because of their ongoing substance use or other medical conditions. Appeals require the beneficiary or their provider to compile all the same documents that were submitted to the plan for authorization and further justify why the care is needed – they are time-consuming and cause delays in care and unnecessary stress to a beneficiary who is already struggling.

The appeals procedures in Medicare and Medicaid have different requirements that make requesting reconsideration even more challenging for dual-eligible individuals. In traditional fee-for-service Medicare, beneficiaries appeal to the local Medicare Administrative Contractor, and if that appeal is not successful, then they can request a Qualified Independent Contractor (QIC) reconsideration. QICs have their own medical professionals who review the denied claim, as well as any additional information the beneficiary or their provider submits, to determine if the benefit is medically necessary and therefore should be covered. If the denied care meets the cost threshold ([\\$180 in 2023](#)), then the beneficiary can request a hearing with an administrative law judge, and then subsequently appeal to the Medicare Appeals Council and seek judicial review in federal district court. Medicaid appeals vary by state, but [all beneficiaries have a right to a state fair hearing](#). Dual-eligible individuals must navigate these two separate processes that utilize different timelines and forms, while also participating in stressful hearings to justify their need for treatment with far more limited resources than the plans they are opposing.

Similar to the previous issues discussed, these appeal processes are even more complicated when individuals are enrolled in Medicare Advantage and/or Medicaid managed care plans. In those cases, the beneficiary must first submit an appeal to the health plan before they can pursue the other administrative remedies. Easy-to-navigate and simple appeals processes are critical because few individuals – [just 1%](#) – take advantage of this opportunity, even though the vast majority of appeals – 75% – result in the plan’s initial decision being

overturned in favor of the beneficiary. Medicare Advantage has structured its appeal process to aid beneficiaries by requiring a denial by the plan to be [automatically sent to an independent review entity](#) for a second level of review. The high reversal rate demonstrates the importance of improving access to appeals for dual-eligible individuals and further suggests that Medicare Advantage plans too often deny care that should have been covered.

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CMS recently finalized a rule that requires Medicare Advantage plans to follow the same clinical criteria as traditional Medicare when making coverage decisions. It is unclear how this provision will be enforced, and not all traditional Medicare rules align with the generally accepted standards of care for substance use disorder treatment.<sup>18</sup> Even if coverage is denied under Medicare, dual-eligible individuals may still be able to get the treatment authorized under Medicaid, particularly in the states that have adopted evidence-based placement criteria for substance use disorder treatment.<sup>19</sup> Beneficiaries may, however, be deterred from pursuing this option after receiving the initial denial and assuming that their treatment will not be covered.



## 6. Racial and Ethnic Disparities

The ongoing opioid public health emergency and skyrocketing rate of overdose deaths have disproportionately harmed Black, Hispanic, and American Indian and Alaska Native communities. In 2020, Black men ages 65 and older were nearly [seven times more likely](#) to die from an overdose than white men ages 65 and older. [Greater disparities in overdose deaths](#) are found in counties with more income inequality, especially among Black people. [Access to treatment is also inequitable](#), with only about one in every twelve Black people with a substance use disorder having a history of receiving substance use disorder treatment, and one in ten Hispanic and American Indian and Alaska Native people. [About 19% of white Medicare beneficiaries with an opioid use disorder](#) received medications for opioid use disorder, compared to 15% of Black beneficiaries, 15% of Hispanic beneficiaries, and 11% of Asian/Pacific Islander beneficiaries. Racial disparities in treatment access are [more pronounced](#) for Medicare beneficiaries who are eligible due to disability than for older adults.

**About 19% of white Medicare beneficiaries with an opioid use disorder received medications for opioid use disorder, compared to 15% of Black beneficiaries, 15% of Hispanic beneficiaries, and 11% of Asian/Pacific Islander beneficiaries.**

While Medicaid, unlike Medicare, covers the full range of substance use disorder treatment facilities, not all dual-eligible beneficiaries have equitable access to these settings of care. Counties with a higher percentage of Black residents (as well as rural and uninsured residents) are [less likely](#) to have at least one outpatient substance use disorder facility that accepts Medicaid. This means that many Black dual-eligible individuals are forced to travel farther to access substance use disorder treatment that is covered by their insurance, which translates to greater travel costs as well as greater disruption to their lives.

Additionally, even though buprenorphine – a medication for opioid use disorder – is covered by both Medicare and Medicaid, many providers who can prescribe this medication only take patients who can pay out-of-pocket or who have private insurance. Between 2004-2015, only [18.9%](#) of buprenorphine visits were reimbursed by Medicare or Medicaid, compared to 39.6% self-pay and 33.9% private insurance, with significantly greater access among white individuals than those who identified as Black or any other race. Interestingly, dual-eligible individuals in fee-for-service Medicare are [more likely](#) to receive medications for opioid use disorder than Medicare-only beneficiaries. This may occur because Medicaid coverage removes financial barriers to these medications – as does traditional Medicare for opioid treatment programs – and prompts greater willingness to seek them. However, dual-eligible individuals and Black and Hispanic individuals are [more likely](#) to enroll in Medicare Advantage plans than Medicare-only individuals, where cost and access to providers pose greater barriers. These findings suggest that treatment access and cost remain significant barriers to substance use disorder treatment for Black and brown individuals in Medicare and Medicaid, as well as systemic racism in the health care system.

## RECOMMENDATIONS

### 1. Incentivize and promote integration of Medicare and Medicaid benefits, with a focus on comprehensive care for substance use disorders.

The current structure of Medicare and Medicaid fosters misaligned incentives for treating and investing in treatment for dual-eligible beneficiaries. When states invest in Medicaid services such as enhanced substance use disorder care, dual-eligible beneficiaries are less likely to require acute care or hospitalization. However, [the majority of those more acute care cost savings](#) accrue to Medicare and the federal government, rather than to Medicaid and the state. As a result, both Medicare and Medicaid are [effectively incentivized](#) to shift beneficiaries and their costs to the other program, rather than coordinating care. Fully integrated care plans that provide both Medicare and Medicaid benefits can help ensure that investments in substance use disorder treatment are benefiting dual-eligible individuals, while also reducing the fragmentation and uncoordinated care that so many in this population currently experience.

Despite efforts over the past several years to increase access to integrated models,<sup>20</sup> few dual-eligible individuals are enrolled in integrated care plans. About 30% are enrolled in Medicare Advantage D-SNPs (dual-eligible special needs plans) but [only 3%](#) are enrolled in D-SNPs that are fully integrated. Even the most advanced D-SNP integration can still result in beneficiary confusion and splintered care. For example, CMS does not require Medicare Advantage D-SNPs to have all in-network providers accept both Medicare and Medicaid. Therefore, beneficiaries who seek treatment from an in-network provider may still be improperly denied treatment or be incorrectly billed if the provider does not accept Medicaid.

Congress and CMS should continue to invest in and promote integrated care models that fully coordinate care, cover the full range of substance use disorder treatment, have sufficient provider networks, do not impose unnecessary barriers to care like utilization management, integrate the appeals and grievance process, and comply with the Mental Health Parity and Addiction Equity Act (discussed further below).<sup>21</sup> Any such efforts should be complemented with strong continuity of care protections and out-of-network benefits to ensure that beneficiaries who are transitioning into new plans do not lose access to treatment and can continue to see the providers with whom they have developed relationships. All transitions to integrated care plans should be voluntary, not the result of default enrollment or other requirements.

### 2. Incentivize providers to equitably treat dual-eligible individuals with substance use disorders, particularly Black and brown individuals, and reduce beneficiary cost sharing.

Current reimbursement rates and payment policies in Medicare and Medicaid effectively disincentivize providers from treating dual-eligible individuals. Congress, CMS, states, Medicare Advantage, and Medicaid managed care plans must increase the reimbursement rates for substance use disorder providers and services to cover the full cost of care and optimize provider participation in these programs and networks. This includes, at a minimum, increasing the reimbursement rate for clinical social workers, professional counselors, and marriage and family therapists in Medicare to be comparable to that for non-physician medical practitioners.

**Congress, CMS, states, Medicare Advantage, and Medicaid managed care plans must increase the reimbursement rates for substance use disorder providers and services to cover the full cost of care and optimize provider participation in these programs and networks.**

Such changes must also be coupled with lowering cost sharing for beneficiaries, who are already facing high financial barriers to treatment with limited incomes that are insufficient to meet these costs.<sup>22</sup> Reducing, if not eliminating, cost sharing for substance use disorder treatment would not only help Medicare-only beneficiaries, but it would also ensure that “lesser-of” policies do not result in a reduction of the reimbursement to providers who treat dual-eligible individuals and thereby improve access to treatment. Patients could also reduce their out-of-pocket costs when they see Medicare providers who are not also enrolled in Medicaid.

Additionally, rather than penalizing providers who treat dual-eligible individuals, CMS and Medicare Advantage plans should provide greater financial resources to providers who treat patients with more social risk factors. In areas where there are already known racial and ethnic disparities, such as access to medications for opioid use disorders, greater financial incentives could attract practitioners, particularly Black and brown practitioners. At the same time, both Medicare and Medicaid should invest in initiatives to address social determinants of health that create social risk factors, thereby improving the existing disparities, increasing quality of life, and reducing the need for acute care.

CMS should also require both Medicare Advantage and Medicaid managed care plans to maintain adequate networks of substance use disorder providers – measured by geographic time and distance and by appointment wait time, with identical values across the two programs – including discrete measures for providers and programs that can prescribe medications for opioid use disorder. Such network adequacy requirements would further ensure that plans are contracting with a sufficient number of providers to meet beneficiary needs, including in communities with high proportions of Black and brown individuals who have historically lacked adequate access to buprenorphine and other substance use disorder treatment.

### **3. Streamline and strengthen processes for accessing benefits for substance use disorder treatment.**

Congress and CMS should consider additional strategies to establish greater consistency across insurance programs and remove the unnecessary barriers to care in both Medicare and Medicaid. CMS recently finalized a [rule](#) that would place new requirements on Medicare Advantage plans, Medicaid fee-for-service programs, Medicaid managed care plans, and other health plans to streamline and improve prior authorization processes, including continuity of care protections and timelines for responding to prior authorizations. Congress and CMS should continue to identify and remove utilization management practices that interfere with access to care and establish greater consistency across financing systems to limit the compounding burden on dual-eligible individuals. For example, as recommended by the [American Medical Association](#) (AMA), health plans should never require patients to repeat step therapy protocols or retry therapies that previously failed, even under a different health plan, before qualifying for coverage of a currently effective benefit.

Congress and CMS should take additional steps to increase access to medications for opioid use disorder, especially where there are existing disparities in access. Congress and/or CMS should require all health care financing systems – including Medicare and Medicaid – to remove prior authorizations for the provision of these medications, consistent with the [AMA’s model bill](#) based on [research](#) suggesting that removal of such policies is associated with increased access to care and improved health care outcomes. While Congress has removed cost-sharing requirements for opioid treatment programs in fee-for-service Medicare, Medicare Advantage plans can still impose these costs, as well as cost-sharing for medications for opioid use disorder in office-based settings. To promote greater access to these medications, including for dual-eligible individuals where the burden is shifted to the providers or erroneously billed to beneficiaries, Congress should remove cost sharing for all substance use disorder

medications and CMS should prohibit Medicare Advantage plans from imposing cost sharing on services that do not have cost sharing in fee-for-service Medicare.

Finally, until Medicare covers the full scope of substance use disorder services, settings, and providers, CMS should develop a streamlined and simplified process by which practitioners can receive a Medicare denial for non-covered benefits or for services delivered by a provider that cannot enroll in Medicare. CMS should also identify a better process to ensure that dual-eligible individuals are not charged a deductible or coinsurance when they see a Medicare provider who is not enrolled in Medicaid.

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

Unlike most Medicaid and commercial health insurance plans, the Parity Act does not apply to Medicare. The Parity Act requires non-discriminatory coverage of substance use disorder and mental health benefits compared to medical/surgical benefits. [Without parity in Medicare](#), beneficiaries do not have coverage of or access to all evidence-based services for substance use disorder and mental health, 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. All the barriers identified in this issue brief could be addressed through non-discriminatory coverage of substance use disorder treatment in Medicare, which would further prevent cost-shifting to individuals, states, and providers. Congress should [apply the Parity Act to all parts of Medicare](#), and [authorize coverage of the full range of services, settings, and providers](#) necessary to treat substance use disorders and mental health conditions.

#### **5. Improve enforcement of the Mental Health Parity and Addiction Equity Act in Medicaid.**

The Parity Act applies to Medicaid managed care plans, alternative benefit plans (the Affordable Care Act's Medicaid expansion population), and the Children's Health Insurance Program (CHIP), which together cover over 70% of Medicaid enrollees. CMS has lagged behind in its enforcement of the Parity Act in Medicaid compared to sister agencies that require private health plans to conduct an annual analysis of their parity compliance and conduct ongoing oversight of plan compliance with this civil rights law. The lack of oversight and enforcement is especially problematic because [Medicaid is the largest single source of funding for substance use disorder and mental health services in the United States](#), and Medicaid enrollees are [more likely](#) to have substance use disorders and mental health conditions than individuals with private health insurance.

In September 2023, [CMS issued a request](#) for comments on processes for assessing compliance with the Parity Act in Medicaid. [CMS should improve Medicaid compliance with the Parity Act](#), and accordingly, access to substance use disorder and mental health care for dual-eligible individuals. Furthermore, certain integrated care plans for dual-eligible individuals must comply with the Parity Act at least to some extent, and others have the option to do so.<sup>23</sup> CMS should be reviewing and assessing those plans for non-discriminatory coverage of substance use disorder and mental health care as well.

**CMS should improve Medicaid compliance with the Parity Act, and accordingly, access to substance use disorder and mental health care for dual-eligible individuals.**

## Summary of Recommendations for Improving Access to Substance Use Disorder Care for Dual-Eligible Individuals

	Barriers to Care	Recommendations
<b>Service Billing</b>	Providers who can bill only one program – when coverage and requirements differ – results in both erroneous denials and billing of dual-eligible individuals.	<ol style="list-style-type: none"> <li>1. Cover the full continuum of substance use disorder treatment in Medicare and Medicaid.</li> <li>2. Increase access to fully integrated plans for dual-eligible individuals.</li> <li>3. Develop streamlined claim processes for providers who are enrolled in only one program to ensure reimbursement.</li> </ol>
<b>Network Access Standards</b>	Medicare and Medicaid have different appointment wait time requirements and criteria for tracking network substance use disorder and mental health providers.	<ol style="list-style-type: none"> <li>1. Establish consistent network access standards for substance use disorder and mental health providers across Medicare and Medicaid.</li> <li>2. Separately track substance use disorder providers from mental health providers for network access standards.</li> </ol>
<b>Reimbursement Policies</b>	“Lesser of” policies in Medicaid are compounded by discriminatorily lower rates for substance use disorder providers in Medicare, as well as in Medicaid, which leads to limited numbers of providers who enroll in one or both programs.	<ol style="list-style-type: none"> <li>1. Apply the Parity Act to Medicare and conduct comprehensive analyses of reimbursement rates and network adequacy for both Medicare and Medicaid, as well as integrated care plans.</li> <li>2. Provide financial incentives to substance use disorder providers who treat dual-eligible individuals.</li> </ol>
<b>Utilization Management</b>	Medicare and Medicaid have different medical necessity criteria and clinical review standards that lead to improper denials of care and delays in treatment.	<ol style="list-style-type: none"> <li>1. Eliminate over-burdensome and unnecessary utilization management practices.</li> <li>2. Require Medicare and Medicaid to follow generally accepted standards of care (ASAM Criteria) for coverage decisions.</li> </ol>
<b>Appeals</b>	Appeals processes in Medicare and Medicaid are different and overly burdensome for beneficiaries.	<ol style="list-style-type: none"> <li>1. Streamline the appeals process for dual-eligible individuals.</li> <li>2. Require automatic reconsideration by an independent reviewer for all plan denials of an appeal for dual-eligible individuals.</li> </ol>
<b>Access to Medications for Opioid Use Disorder (MOUD)</b>	Too few Medicare and Medicaid beneficiaries are able to access MOUD, with lower rates of access for Black and brown individuals.	<ol style="list-style-type: none"> <li>1. Remove cost-sharing and prior authorization requirements for MOUD.</li> <li>2. Establish consistent network access standards for prescribers of MOUD in Medicare and Medicaid.</li> <li>3. Provide financial incentives and grants to prescribers of MOUD who serve Black and brown beneficiaries and other communities with disparate access to substance use disorder treatment.</li> </ol>

## CONCLUSION

Dual-eligible individuals face substantial barriers to substance use disorder treatment because Medicare and Medicaid have different and often uncoordinated benefits, providers, reimbursement policies, utilization management practices, and appeals processes. People who are enrolled in Medicare Advantage and/or Medicaid managed care plans, as well as Black and brown individuals, experience additional access barriers. Congress and CMS can make coverage more equitable and seamless, which is critically important given the great need for services and coordination. Rather than shifting costs between programs, Medicare and Medicaid should be working together to support dual-eligible individuals and ensure equitable access to substance use disorder treatment.

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<sup>1</sup> Data on file with the Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office.

<sup>2</sup> Centers for Medicare & Medicaid Services, “Dually Eligible Individuals – Categories,” <https://www.cms.gov/medicare-medicare-coordination/medicare-and-medicare-coordination/medicare-medicare-coordination-office/downloads/medicaremedicaidenrolleecategories.pdf> (accessed Dec. 7, 2023); Maria T. Pena et al., “Enrollment and Spending Patterns Among Medicare-Medicaid Enrollees (Dual Eligibles),” KFF (Jan. 31, 2023), <https://www.kff.org/medicaid/issue-brief/enrollment-and-spending-patterns-among-medicare-medicare-enrollees-dual-eligibles/>.

<sup>3</sup> Maria T. Pena et al., “A Profile of Medicare-Medicaid Enrollees (Dual Eligibles),” KFF (Jan. 31, 2023), <https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicare-enrollees-dual-eligibles/>.

<sup>4</sup> Based on the 2021 National Survey on Drug Use and Health (NSDUH).

<sup>5</sup> See Maria T. Pena, Maiss Mohamed & Alice Burns, “Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals,” KFF (Apr. 27, 2023), <https://www.kff.org/medicaid/issue-brief/medicaid-arrangements-to-coordinate-medicare-and-medicare-for-dual-eligible-individuals/>; Alexandra Kruse & Michelle H. Soper, “State Efforts to Integrate Care for Dually Eligible Beneficiaries: 2020 Update,” Center for Health Care Strategies, Inc. (2020), [https://www.chcs.org/media/State-Efforts-to-Integrate-Care-for-Dually-Eligible-Beneficiaries\\_022720.pdf](https://www.chcs.org/media/State-Efforts-to-Integrate-Care-for-Dually-Eligible-Beneficiaries_022720.pdf).

<sup>6</sup> See MACPAC, “Chapter 4: Access to Substance Use Disorder Treatment in Medicaid” (June 2018), <https://www.macpac.gov/wp-content/uploads/2018/06/Access-to-Substance-Use-Disorder-Treatment-in-Medicaid.pdf>; but see Legal Action Center, “Modernize Medicare to Treat Substance Use Disorders: A Roadmap for Reform” (Oct. 2021), <https://www.lac.org/assets/files/Roadmap-for-Reform-Medicare-SUD-2021.10.15-akformatted.pdf>.

<sup>7</sup> MACPAC, “Report to Congress on Medicaid and CHIP” 88 (June 2018), <https://www.macpac.gov/wp-content/uploads/2018/06/June-2018-Report-to-Congress-on-Medicaid-and-CHIP.pdf>. Additionally, seven states (AK, CA, CO, IN, MN, NJ, and NM) used Section 1115 demonstration waivers to add or expand coverage of intensive outpatient services. RTI International, “Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Features of State Approaches to Improve Medicaid SUD Treatment Delivery Systems,” 4 (Nov. 2022).

<sup>8</sup> MACPAC, “Report to Congress on Medicaid and CHIP,” *supra* note 7 at 88. Additionally, eight states (AK, CA, ID, KY, NJ, NM, OK, and VA) used Section 1115 demonstration waivers to add or expand coverage of partial hospitalization services. RTI International, “Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Features of State Approaches to Improve Medicaid SUD Treatment Delivery Systems,” *supra* note 7 at 4.

<sup>9</sup> MACPAC, “Report to Congress on Medicaid and CHIP,” *supra* note 7 at 89. Seventeen states cover all four residential levels of care. Sixteen states and D.C. pay for two or three services. Five states pay for just one level of residential care. Additionally, sixteen states used Section 1115 demonstration waivers to add or expand coverage of residential treatment services. RTI International, “Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Features of State Approaches to Improve Medicaid SUD Treatment Delivery Systems,” *supra* note 7 at 5.

<sup>10</sup> MACPAC, “Report to Congress on Medicaid and CHIP” *supra* note 7 at 95. Furthermore, one-third of substance use disorder treatment facilities in Section 1115 demonstration states did not accept Medicaid in 2016, and less than half of the facilities that did offered medications for opioid use disorder. RTI International, “Medicaid Section 1115 Substance Use Disorder Demonstrations: An In-Depth Look Into Pre-Demonstration Measures of SUD Need, Treatment Use, Availability, and Outcomes Across States” (Nov. 2022).

<sup>11</sup> MACPAC, “Report to Congress on Medicaid and CHIP” *supra* note 7 at 95.

<sup>12</sup> The Centers for Medicare & Medicaid Services (CMS) recently proposed a rule that would require Medicare Advantage plans to track their access to outpatient mental health and substance use disorder services as one provider category, but CMS’s failure to separate out these two conditions means that a plan could meet the regulatory requirement by contracting with mental health providers alone. Centers for Medicare & Medicaid Services, “Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program,” 88 Fed. Reg. 78476, 78483-86 (proposed Nov. 15, 2023).

<sup>13</sup> Centers for Medicare & Medicaid Services, “Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program,” 88 Fed. Reg. 22120, 22173-74 (Apr. 12, 2023).

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<sup>14</sup> Centers for Medicare & Medicaid Services, “Medicaid and Children’s Health Insurance Program Managed Care Access, Finance, and Quality,” 88 Fed. Reg. 28092, 28098-99 (proposed May 3, 2023); see also Elizabeth Hinton & Jada Raphael, “Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes,” KFF (June 15, 2023), <https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-network-adequacy-access-current-standards-and-proposed-changes/>.

<sup>15</sup> 42 C.F.R. 447.20(a)(2).

<sup>16</sup> Centers for Medicare & Medicaid Services, Medicare and Medicaid Programs: CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 88 Fed. Reg. 52262, 52320, 52366 (Aug. 7, 2023); see also, Marua Calsyn & Madeline Twomey, “Rethinking the RUC: Reforming How Medicare Pays for Doctors’ Services” (July 13, 2018), <https://www.americanprogress.org/article/rethinking-the-ruc/>.

<sup>17</sup> Prior authorization is when a provider must seek approval from the health plan before delivering care. Concurrent authorization requires the provider to seek re-approval to continue ongoing treatment. Retrospective review occurs when the health plan determines coverage after treatment has been delivered. The medical necessity criteria are the guidelines a health plan uses when determining the type, frequency, and location of care. Benefit design refers to which benefits a health plan will cover. Network tier design involves health plans giving preferred status to certain providers and charging lower costs to members when they use certain providers and higher costs for others. Similarly, drug tier design involves health plans charging members a lower cost for certain medications and a higher cost for others depending on the formulary tier. Referral protocols are when health plans require a patient to get one provider to serve as a gatekeeper to determine that care from another provider is necessary. Step therapy or fail first policies are health plan practices that require a patient to try and not succeed at least one other course of treatment before the health plan will approve the requested treatment.

<sup>18</sup> Centers for Medicare & Medicaid Services, “Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program,” 88 Fed. Reg. 22120, 22185-205; Legal Action Center, “Calendar Year (CY) 2024 Medicare Advantage Final Rule: Substance Use Disorder and Mental Health Provisions” (April 2023), <https://www.lac.org/assets/files/CY2024-MA-Final-Rule-2023.04.27.pdf>.

<sup>19</sup> RTI International, “Medicaid Section 1115 Substance Use Disorder (SUD) Demonstrations: Features of State Approaches to Improve Medicaid SUD Treatment Delivery Systems,” *supra* note 7 at 7.

<sup>20</sup> See, e.g., Centers for Medicare & Medicaid Services, “Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program,” 88 Fed. Reg. 78476, 78566 (proposed Nov. 15, 2023).

<sup>21</sup> See Centers for Medicare & Medicaid Services, “Medicaid and Children’s Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children’s Health Insurance Program (CHIP), and Alternative Benefit Plans,” 81 Fed. Reg. 18390, 18424 (Mar. 30, 2016) (noting that the Parity Act does not apply to all integrated care plans, but that CMS would be providing technical assistance as needed about how to structure and assess capitated managed care plans in the CMS Financial Alignment Initiative for compliance with the Parity Act). CMS has also identified that Special Needs Plans (SNPs) should have specially designed plan benefit packages that go beyond the provision of basic Medicare Parts A and B, and that parity between medical and mental health benefits and services is one such example); Centers for Medicare & Medicaid Services, “Medicare Managed Care Manual: Chapter 16-B: Special Needs Plans” Section 70.2 (Aug. 11, 2023), <https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c16b.pdf>.

<sup>22</sup> See William J. Parish et al., “Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers,” *Am. J. Prev. Med.* (Mar. 21, 2022), <https://pubmed.ncbi.nlm.nih.gov/35331570/>; Maria T. Pena et al., “A Profile of Medicare-Medicaid Enrollees (Dual Eligibles),” *supra* note 3.

<sup>23</sup> See *supra* note 21.