Under-Diagnosed and Under-Covered:
Claims Data Reveal Significant Medicare Gaps in SUD Treatment in 2020

The goal of this research was to understand whether and where Medicare beneficiaries are accessing substance use disorder (SUD) treatment. RTI International analyzed 2020 claims and encounter data for Medicare beneficiaries who were enrolled in Fee-for-Service (FFS) Medicare and Medicare Advantage (MA).[1] This foundational review examines available and accessible SUD treatment prior to several important expansions in Medicare,[2] and thus serves as a benchmark to measure the impact of the new coverage.

Key Findings

1. **SUDs among Medicare beneficiaries are under-diagnosed.**
2. **Most Medicare beneficiaries who received SUD treatment did so in hospital settings.**
3. **MA plans denied hospital-based SUD treatment at much higher rates than FFS Medicare.**
4. **Very few Medicare beneficiaries received intermediate levels of SUD treatment or care in specialty settings, demonstrating the lack of Medicare coverage of the most common settings of care.**

1. Substance use disorders among Medicare beneficiaries are under-diagnosed.

In 2020, there were 3,750,809 Medicare beneficiaries with an SUD diagnosis based on claims data,[3] representing approximately 5.9% of Medicare beneficiaries. A larger portion of Medicare beneficiaries with an SUD were enrolled in MA plans (55.5%) than in FFS Medicare (44.5%). A significant number of Medicare beneficiaries with SUDs are not diagnosed, based on estimates from SAMHSA's National Survey on Drug Use and Health (NSDUH). The 2022 NSDUH data estimate that approximately 5.7 million Medicare beneficiaries had an SUD, representing 9% of

[1] The 2020 data is the most complete data currently available.
[2] As of January 2024, Medicare now covers intensive outpatient programs (IOP), marriage and family therapists, and mental health counselors including masters-level addiction counselors. Notably though, not all states license or certify masters-level addiction counselors that would meet the requirements of a mental health counselor under Medicare. IOP is only available in hospital outpatient departments, community mental health centers, federally qualified health centers, and rural health clinics. It is also available for Medicare beneficiaries with opioid use disorder in opioid treatment programs as an add-on code.
[3] This analysis did not examine office-based visits or opioid treatment programs.

Medicare beneficiaries;[4] a 35% gap between the number of beneficiaries with SUDs and those receiving care in non-office-based settings.[5]

***Recommendation*:** CMS must continue to improve access to screening and treatment in Medicare to better identify individuals with an SUD and work with Congress to cover the full range of SUD services and providers, consistent with all other payer systems. At a minimum, this should include requiring hospitals and emergency departments to have screening, medications for addiction treatment, and connections to ongoing, step-down levels of care. Furthermore, CMS must develop discrete network adequacy standards for SUD providers and facilities to ensure that beneficiaries in MA plans have sufficient access to providers who can diagnose and treat their SUDs.

2. Most Medicare beneficiaries who received substance use disorder treatment did so in hospital settings.

Medicare beneficiaries receive most SUD care in hospital settings, with higher rates of service use for both FFS Medicare beneficiaries and MA beneficiaries than other care settings. Approximately 1.75% of Medicare beneficiaries with a primary SUD diagnosis and 15.9% with a secondary SUD diagnosis received hospital inpatient treatment. Approximately 4.87% of Medicare beneficiaries with a primary SUD diagnosis and 8.1% with a secondary SUD diagnosis received hospital outpatient treatment.[6] By contrast, only 0.12% of Medicare beneficiaries with a diagnosed SUD received treatment in a community mental health center (CMHC) – the only covered community-based setting as of 2020.[7] This data suggests that many Medicare beneficiaries with SUD are relying on hospitals for their treatment, which is often more expensive and less specialized than community-

This data suggests that many Medicare beneficiaries with SUD are relying on hospitals for their treatment, which is often more expensive and less specialized than community-based mental health or SUD facilities or clinics.

[4] *See* NSDUH Public Use Files. In 2022, approximately 6% of Medicare beneficiaries ages 65 and older had an SUD, and approximately 25% of Medicare beneficiaries under age 65 had an SUD. Previous analyses based on the 2015-2019 NSDUH data revealed that approximately 1.7 million Medicare beneficiaries had an SUD. It is important to note that between 2019 and 2020, SAMHSA changed its definition and methodology for SUD to reflect the DSM-5, rather than the DSM-IV.

[5] Another plausible explanation for the difference in data, or potentially some of the difference, is an increase in the prevalence of SUD between 2020 and 2022. Some individuals with SUD also may not be captured in this data if they received SUD treatment in an office-based setting alone or an opioid treatment program, two common settings of care that were not included in this claims analysis.

[6] The 2022 NSDUH data show that approximately 24% of Medicare beneficiaries with an SUD received treatment for their disorder, including about 8% receiving inpatient SUD treatment and 19% receiving outpatient SUD treatment.

[7] Not all states have CMHCs. Some states have other types of community-based mental or behavioral health treatment facilities or clinics that do not meet Medicare's definition of a CMHC and are therefore not eligible for Medicare payment.

based mental health or SUD facilities or clinics. As of 2024, Medicare still does not cover community-based SUD treatment facilities other than opioid treatment programs.[8]

Notably, FFS Medicare beneficiaries were more likely to access both inpatient and outpatient hospital-based care than beneficiaries in MA plans. Approximately 2.00% of FFS Medicare beneficiaries compared to 1.54% of MA beneficiaries with a primary SUD diagnosis received hospital inpatient SUD treatment. Approximately 6.02% of FFS Medicare beneficiaries compared to 3.95% of MA beneficiaries with a primary SUD diagnosis received hospital outpatient SUD treatment.

***Recommendation*:** Congress must authorize Medicare coverage of community-based SUD treatment facilities to ensure beneficiaries can get the specialty care they need.

3. Medicare Advantage plans denied hospital-based substance use disorder treatment at much higher rates than fee-for-service Medicare.

The 2020 data reveal that MA plans denied almost half of the claims submitted for inpatient SUD treatment. MA plans denied 45.3% of hospital inpatient claims with a primary SUD diagnosis, compared to only 3.3% of hospital inpatient claims denied by FFS Medicare. Denial rates were also much higher in MA plans for hospital outpatient SUD claims: 10.9% in MA compared to 2.2% in FFS Medicare. Previous research focusing on other types of treatment have identified high rates of denials among MA plans, including an alarming number of denials of prior authorization requests that met Medicare coverage rules (13%) and thus would have been covered under FFS Medicare.[9] RTI's claims analysis suggests that disproportionately higher denial rates by MA plans extend to SUD treatment as well, especially inpatient services. These findings are particularly concerning given the low rate of treatment access in intermediate levels of care, which suggests that these claims are being denied but MA beneficiaries are not able to access other types of care. As of 2024, MA plans are required to

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[8] After passage of the SUPPORT Act in 2018, Medicare began covering opioid treatment programs (OTPs) in 2020. This data was not included in the analysis, although according to a report by the U.S. Department of Health & Human Services Office of Inspector General, approximately 39,602 Medicare beneficiaries received medications for opioid use disorder (MOUD) at an OTP in 2020, representing less than 4% of Medicare beneficiaries with an opioid use disorder. As of 2022, approximately 6% of Medicare beneficiaries with an opioid use disorder received MOUD at an OTP.

[9] In 2022, almost all MA enrollees (99%) were in plans that require prior authorizations for at least some SUD services, including 94% for inpatient stays in a psychiatric hospital, 92% for partial hospitalization programs, 85% for opioid treatment program services, 85% for mental health therapy, and 83% for outpatient SUD services.

use coverage criteria that comply with FFS Medicare,[10] but it remains unclear how and to what extent this regulation will be enforced.

***Recommendation*:** CMS must improve data collection on and oversight of MA plan authorization practices and denials of SUD treatment and hold plans accountable for failing to comply with the coverage criteria in FFS Medicare.

4. Very few Medicare beneficiaries received intermediate levels of SUD treatment or care in specialty settings, demonstrating the lack of Medicare coverage of the most common settings of care.

A fraction of Medicare beneficiaries with an SUD received intermediate levels of SUD treatment (that is, more intensive than standard outpatient treatment but less intensive than inpatient treatment) or treatment from a CMHC. CMHCs and partial hospitalization programs (PHPs) are covered under Medicare, but less than one quarter of one percent of Medicare beneficiaries with an SUD accessed this treatment. About 0.16% of Medicare beneficiaries with a primary diagnosis of SUD received PHP (0.23% in FFS Medicare and 0.10% in MA) and about 0.12% of Medicare beneficiaries with a primary diagnosis of SUD received treatment at a CMHC (0.20% in FFS Medicare and 0.06% in MA). By contrast, according to a similar claims data analysis of Medicaid beneficiaries by KFF, approximately 8% of Medicaid enrollees with an SUD in the same time period accessed PHP or intensive outpatient programs (IOP) in the same time period.[11]

Community mental health centers and partial hospitalization programs are covered under Medicare, but less than one quarter of one percent of Medicare beneficiaries with an SUD accessed this treatment.

The low rate of access to intermediate levels of care overall, and particularly the lower rate of access in MA plans, is especially concerning given the high rate of MA denials for inpatient and outpatient hospital-based care. Medicare beneficiaries do not have meaningful access to appropriate levels of care when the prescribed care has been denied. In these circumstances, beneficiaries may be foregoing care altogether or forced to pay out of pocket for the SUD treatment they need.

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[10] 42 C.F.R. § 422.101. If the coverage criteria in FFS Medicare are not fully established, an MA organization "may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature." § 422.101(b)(6).

[11] Other factors may contribute to greater access to intermediate SUD levels of care among Medicaid enrollees compared to Medicare beneficiaries. For example, the cost of these services may be an additional barrier for Medicare beneficiaries, as FFS Medicare has a deductible and co-insurance, and the majority of MA plans have co-payment requirements for PHP. Most state Medicaid programs do not have any cost-sharing for PHP, or else they are minimal.

The fraction of Medicare beneficiaries who received any of these intermediate levels of SUD care or treatment in a specialty community-based setting, especially as compared to inpatient and standard outpatient care, demonstrates that Medicare fails to meaningfully cover the full continuum of SUD treatment.

Access to SUD care in PHPs and CMHCs was only marginally better than access to SUD care in the levels of services that were not covered by Medicare in 2020. For example, a very small number of Medicare claims with a primary SUD diagnosis were covered at the IOP level, even though Medicare did not cover this level of care until 2024, and in residential settings, which remains a non-covered service in Medicare. These claims may reflect that other services were delivered to Medicare beneficiaries in these levels of care, or by other providers. There was a slightly higher number of claims and lower rate of denials among MA plans compared to FFS Medicare for IOP and residential treatment, which may reflect that these services were covered as supplemental benefits by a small number of plans.[12] Nonetheless, the fraction of Medicare beneficiaries who received any of these intermediate levels of SUD care or treatment in a specialty community-based setting, especially as compared to inpatient and standard outpatient care, demonstrates that Medicare fails to meaningfully cover the full continuum of SUD treatment.

***Recommendation*:** Congress must authorize Medicare coverage of residential SUD treatment (H.R.9232/S.4860) and all of the levels of care in community-based SUD treatment facilities. Both Congress and CMS must further ensure that coverage of IOPs and PHPs align with The ASAM Criteria to ensure that the benefits and coverage criteria are consistent with generally accepted standards of care.

Conclusion

RTI International's Medicare claims analysis confirms our previous legal research that Medicare's coverage of SUD treatment is essentially bookended: covering only the least and most intensive levels of care. Congress and CMS have made important progress in recent years (such as the new coverage of IOP services and addiction counselors), and there is more to be done to address the gaps in Medicare coverage of SUD treatment and improve access to care.

1. CMS must continue to improve access to screening and treatment in Medicare to better identify individuals with an SUD and work with Congress to cover the full range of SUD services and providers, consistent with all other payer systems. At a minimum, this should include requiring hospitals and emergency departments to have screening, medications for addiction treatment, and connections to ongoing, step-down levels of care.

[12] According to a recent report by the U.S. Government Accountability Office (GAO), residential treatment for behavioral health conditions was covered by less than 1% of MA plans.

2. CMS must develop discrete network adequacy standards for SUD providers and facilities to ensure that beneficiaries in MA plans have sufficient access to providers who can diagnose and treat their SUDs.
3. Congress must authorize Medicare coverage of community-based SUD treatment facilities to ensure beneficiaries can get the specialty care they need.
4. CMS must improve data collection on and oversight of MA denials of SUD treatment and hold plans accountable for failing to comply with the coverage criteria in FFS Medicare.
5. Congress must authorize Medicare coverage of residential SUD treatment (H.R.9232/S.4860) and all of the levels of care in community-based SUD treatment facilities. Congress and CMS must further ensure that coverage of IOPs and PHPs align with The ASAM Criteria to ensure that the benefits and coverage criteria are consistent with generally accepted standards of care.