Closing the Medicare Coverage Gap: New Research and Policy Initiatives

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2023 ASAM Annual Conference, April 14, 2023, 1:15pm

Learning Objectives

- Compare and contrast Medicare's current coverage of substance use disorder treatment with that of other types of insurance, including Medicaid and private insurance, and with the current care delivery system.
- Identify the prevalence of substance use disorders among Medicare beneficiaries, including the high rate at which these conditions go untreated and the main reasons beneficiaries forgo treatment.
- Identify legislative and regulatory reforms that would ameliorate this disparity and summarize the recent research on the cost of expanding substance use disorder treatment in Medicare that support these proposals.

Disclosure Information

Closing the Medicare Coverage Gap: New Research and Policy Initiatives

April 14, 2022, 1:15-2:30pm

Deborah Steinberg, J.D., Legal Action Center

- No Disclosures

Medicare Background

- Eligible individuals are people ages 65+ or those under 65 with chronic disabilities
- Approximately 64 million Americans
- Types of coverage
  - Part A: Hospital insurance
  - Part B: Medical insurance
  - Part D: Prescription drug coverage
  - Part C: Medicare Advantage

Reference #1

Medicare's Disparity

- Medicare is not subject to the Mental Health Parity and Addiction Equity Act (the Parity Act), which bars discrimination in coverage of and access to substance use disorder and mental health benefits in health insurance
- Inconsistency across payer types, because most Medicaid and commercial insurance plans are subject to this law
- Other payers use Medicare as a benchmark, such as for reimbursement rates and network adequacy standards, so those plans are using inequitable baselines
- Shifts costs to other players (including states, providers, and beneficiaries) when coverage is inadequate

References #1-3

Barriers to Substance Use Disorder Treatment in Medicare

- Lack of coverage of the full continuum of care
  - ASAM levels of care
  - Crisis services (i.e. mobile crisis teams, crisis stabilization services)
  - Contingency management
- Lack of coverage of the full range of providers and settings, especially those in the community, and discriminatory reimbursement rates
- Inadequate networks of substance use disorder providers and shortage of culturally effective providers
- Burdensome and restrictive utilization management practices such as prior authorizations, step therapy, and medical necessity criteria

References #1-3

Crosswalk to ASAM Criteria: Coverage

ASAM Level	Medicare Coverage
Level 0.5 – Early Intervention	SBIRT; Alcohol Misuse Screening and Counseling; Annual screening for potential SUDs; Initiation of MOUD in EDs
Level 1 – Outpatient Services	Counseling and treatment in office-based settings and hospital outpatient departments; office-based counseling and care management; Opioid Treatment Programs; telehealth
Level 2 – Intensive Outpatient/Partial Hospitalization Services	Intensive Outpatient Programs (starting in 2024) and Partial Hospitalization Programs in specified settings
Level 3 – Residential/Inpatient Services	Medically Monitored Intensive Inpatient Services in hospital settings (3.7)
Level 4 – Medically Managed Intensive Inpatient Services	Hospital-based intensive inpatient SUD treatment
Withdrawal Management	Office- and hospital-based withdrawal management

References #1, 4

Crosswalk to ASAM Criteria: Gaps

ASAM Level	Medicare Coverage Gaps
Level 0.5 – Early Intervention	Limited providers (no coverage of Licensed and Certified Substance Use Disorder Counselors – i.e. Alcohol and Drug or Addiction Counselors)
Level 1 – Outpatient Services	Limited providers and settings (no coverage of free-standing community based substance use disorder facilities)
Level 2 – Intensive Outpatient/Partial Hospitalization Services	Substance use disorder services, providers, and settings are not specified, and beneficiaries with SUDs may be unable to access these levels of care
Level 3 – Residential/Inpatient Services	No coverage of residential services (3.1, 3.3, and 3.5) Limited providers and settings
Level 4 – Medically Managed Intensive Inpatient Services	190-day lifetime limit for inpatient psychiatric care
Withdrawal Management	Limited providers and settings

References #1, 4

Key Recent Changes

- Intensive Outpatient Treatment (2024)
- Mental Health Counselors (including Professional Counselors) and Marriage and Family Therapists (2024)
- Peer Support Specialists (for mobile crisis and behavioral health integration)
- ”General Supervision” for “auxiliary personnel”
- Increased reimbursement rates to opioid treatment programs
- Increased access to telehealth, including audio-only

References #4-5

Disclosure Information

Closing the Medicare Coverage Gap: New Research Findings

April 14, 1:15 – 2:30

Tami L. Mark, PhD., M.B.A

- I am a paid employee of RTI International, a nonprofit research institute. I have no conflicts to declare.

Learning Objectives

- Prevalence and type of SUDs among Medicare beneficiaries.
- Unmet Need of SUD treatment among Medicare beneficiaries
- Cost of expanding SUD Medicare coverage

1.7 Million Medicare Beneficiaries Are Estimated to Have a Past Year SUD

Condition	Overall		< 65		65+	
	N	Pct.	N	Pct.	N	Pct.
Any illicit drug, prescription drug, or alcohol Dependence/abuse	1,669,326	3.0%	750,056	8.4%	919,270	2.0%
Dependence	951,599	1.7%	504,978	5.7%	446,621	1.0%
Abuse	717,727	1.3%	245,077	2.7%	472,649	1.0%

Source: National Survey of Drug Use and Health (NSDUH), 2015–2019.

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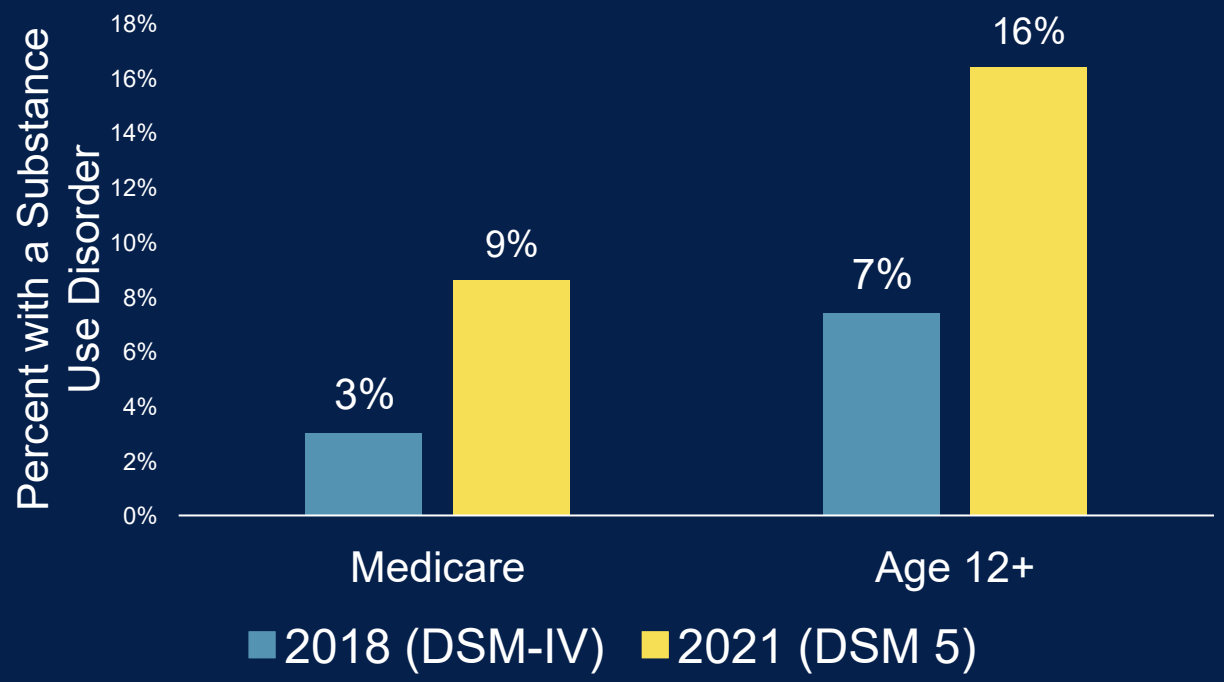
Updated NSDUH Using DSM-5 versus DSM-IV Definition Finds Much Higher Rates SUD Overall and in Medicare Population



Recurrent substance-related legal problems is not part of DSM-5 SUD criteria.
Craving or a strong desire to use the substance was added to DSM-5.
The other ten DSM-5 criteria correspond to DSM-IV criteria.

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Among the 1.7 Million Medicare Beneficiaries with a Past Year SUD, Alcohol Dependence or Abuse Was the Most Common Condition

	All Ages	Less than 65 years of age	Greater than or equal to 65 years of age
Alcohol use disorder	77%	65%	87%
Opioid use disorder (prescription pain relievers, heroin)	14%	21%	9%
Prescription pain reliever use disorder	13%	18%	9%
Heroin use disorder	2%	4%	0%
Marijuana use disorder	10%	17%	4%
Nonopioid prescription drug use disorder (tranquilizers/anxiolytics, stimulants)	6%	10%	2%
Prescription tranquilizers/anxiolytic use disorder	4%	8%	2%
Prescription stimulant use disorder	2%	3%	0%
Methamphetamine use disorder	4%	8%	0%
Cocaine use disorder	4%	8%	0%

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Characteristics of Medicare Beneficiaries With and Without SUD, 65+ and < 65

- Beneficiaries in both age groups with SUD were more likely to be male.
- Beneficiaries < 65 with SUD were also more likely to be unmarried.
- Beneficiaries 65+ with SUD were also more likely to be non-Hispanic white, have a college degree, and be dually-eligible for Medicare and Medicaid.

	< 65		65+	
	No SUD	SUD	No SUD	SUD
Male	45%	69%*	45%	71%*
Non-Hispanic white	65%	65%	78%	87%*
Non-Hispanic Black	20%	17%	9%	8%
Hispanic	10%	10%	7%	3%*
Unmarried	68%	81%*	52%	53%
College graduate	10%	12%	30%	40%*
Dually-eligible for Medicare & Medicaid	40%	48%	9%	14%*
* $p < 0.05$				

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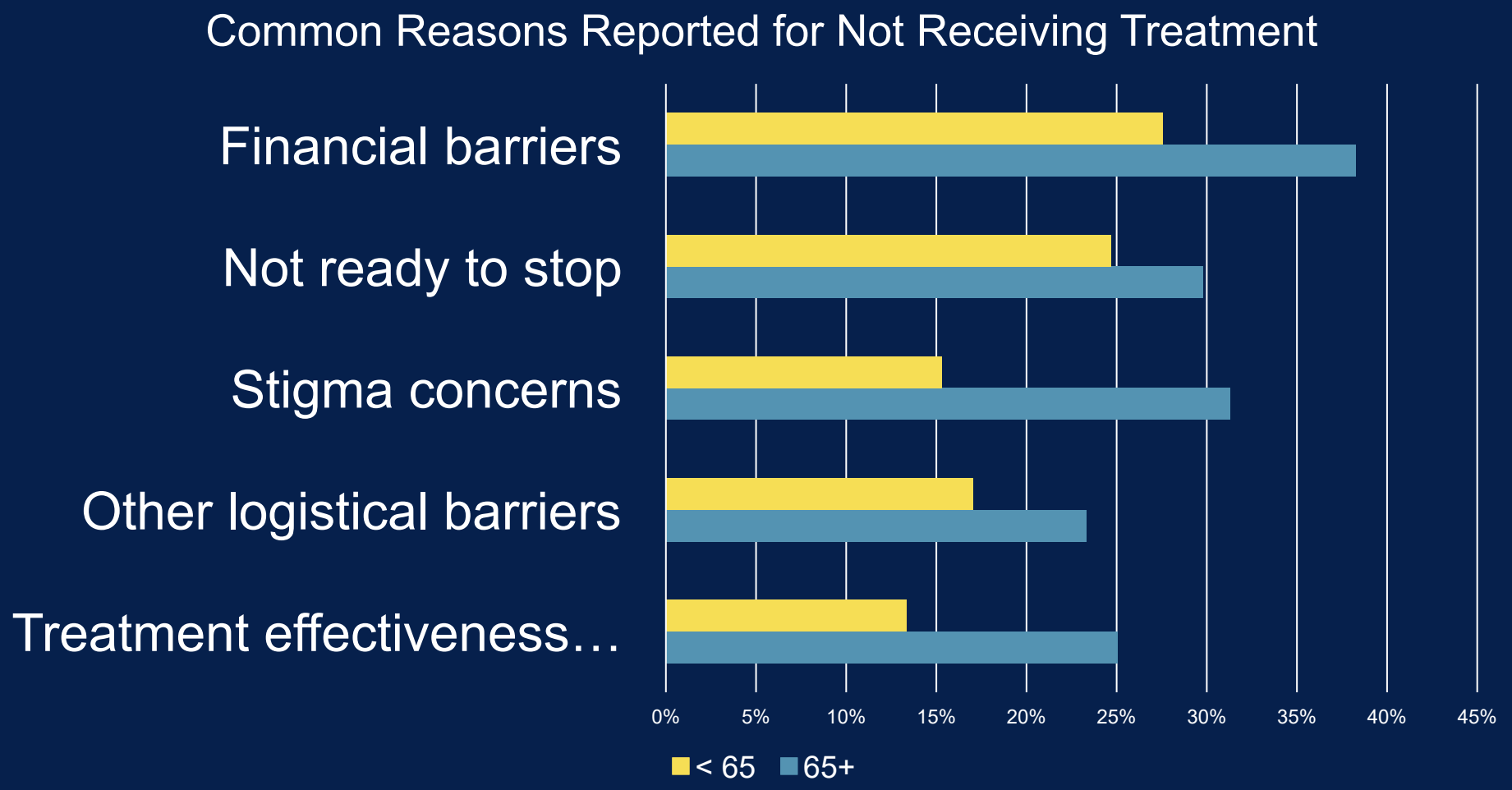
Only 11% of Beneficiaries with a Past Year SUD Received Treatment
Financial Barriers Were the Most Commonly Reported Reason for Not Receiving Treatment
Financial Barriers Were Lower Among <65 than 65+, Perhaps Because of Medicaid Dual Eligibility



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Summary of Key Findings

- SUD is prevalent among Medicare beneficiaries (alcohol, followed by prescription drug abuse)
- Most Medicare beneficiaries with SUD do not receive treatment
- Financial barriers were the most common reason reported for not receiving treatment
- Financial barriers were also greater among 65+ than < 65 population

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Reference

Parish WJ, Mark TL, Weber EM, Steinberg DG. Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers. Am J Prev Med. 2022 Aug;63(2):225-232. doi: 10.1016/j.amepre.2022.01.021. Epub 2022 Mar 21. PMID: 35331570.

The Cost of Adding Substance Use Disorder Services and Professionals to Medicare

Mark,

Budget Impact Analysis of Subset of Excluded Effective Medicare Addiction Treatment Services

- ✓ Intensive outpatient
- ✓ Residential addiction programs
- ✓ Licensed/certified professional counselors

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Methods: Cost of Adding Benefits

- Percentage Medicare beneficiaries with SUD using SUD residential, IOP, counseling services
- Average unit price of residential and IOP treatment day and cost per hour of counseling services
- Average number of days using residential or IOP per year and number of counseling sessions per year

(% Using) x (Price per unit) x (Number of Units)

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Projected Percent of Medicare Beneficiaries that Would Use Each Service if Medicare Coverage Expanded

Sex and Service Type	95% Confidence Interval (CI)	
	Ages 50–64 with Non-Medicare Insurance	Ages 18–64 with Medicare and Medicaid Insurance
Female		
Residential treatment	3.6% (1.5%–5.7%)	3.3% (<0%–6.6%)[a]
IOP treatment	4.1% (1.8%–6.3%)	9.7% (4.3%–15.2%)
Counseling services	3.6% (1.3%–5.9%)	9.2% (2.2%–16.4%)
Male		
Residential treatment	3.2% (1.2%–5.1%)	7.3% (2.4%–12.3%)
IOP treatment	3.9% (1.8%–6.1%)	11.0% (5.6%–16.7%)
Counseling services	3.1% (0.8%–5.3%)	1.5% (<0%–3.0%)[a]

Source: Author's Calculations of National Survey of Drug Use and Health (NSDUH)

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Projected Number of Medicare Beneficiaries that Would Use Each Service

Sex and Service Type	Sensitivity		
	All Ages	Age 65+	Age 18–64
Female			
Number of beneficiaries with SUD	513,399	277,356	236,043
Residential treatment	17,723 (4,389–31,535)	10,029 (4,153–15,906)	7,694 (236–15,629)
IOP treatment	34,065 (15,168–53,276)	11,255 (5,037–17,473)	22,810 (10,131–35,803)
Counseling services	31,707 (8,669–55,157)	9,953 (3,559–16,346)	21,754 (5,110–38,810)
Male			
Number of beneficiaries with SUD	1,155,927	641,915	514,012
Residential treatment	57,913 (20,281–96,167)	20,376 (7,798–32,953)	37,538 (12,483–63,214)
IOP treatment	81,964 (40,040–124,588)	25,236 (11,509–38,963)	56,728 (28,531–85,625)
Counseling services	27,183 (5,920–49,347)	19,712 (5,406–34,018)	7,471 (514–15,329)

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Predicted Number of Medicare Beneficiaries who would use each service

Service Type	Number of Users
Residential	75, 637
Intensive Outpatient	116,029
Counseling Services	58,890

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Price Estimates

Service	Price	Data Source
Residential	$618	Survey by Beetham et al.
Intensive Outpatient	$250	Virginia Medicaid
Counseling	$23	Bureau of Labor Statistics

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Intensity of Service Use Estimates

Service	Estimates (per year)	Source / Assumptions
Residential	20 days	Beetham et al.,
Intensive Outpatient	36 days	3 days x per week for 12 weeks
Counseling	72 hours	3 hours per week for 24 weeks

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Cost to Medicare of Adding Residential, Intensive Outpatient, Professional/Certified Counselors, in Millions of Dollars

Medicare Spending Changes	Change in Medicare Spending (Range)		
	Per Year	5-Year	10-Year
Increases in direct spending			
Providing coverage for residential treatment for substance use disorder	$935 ($88–$2,904)	$4,281 ($403–$13,299)	$7,975 ($751–$24,771)
Providing coverage for intensive outpatient treatment for substance use disorder	$928 ($298–$1,921)	$4,251 ($1,365–$8,797)	$7,918 ($2,543–$16,386)
Allowing certified drug counselors to bill Medicare	$66 ($12–$184)	$302 ($53–$844)	$563 ($99–$1,572)
Total (a)	$1,929	$8,834	$16,455

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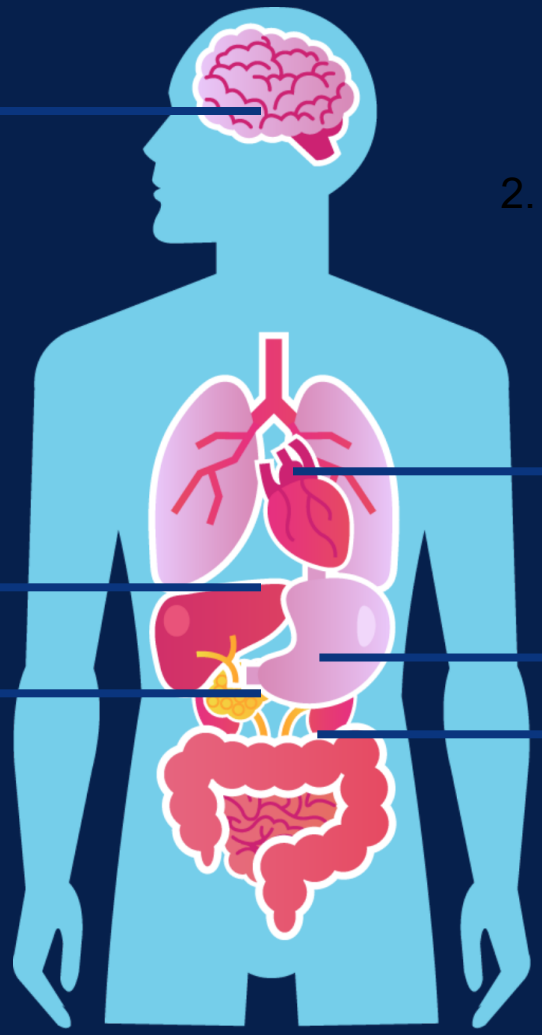
Substance Use Increases the Risk of 200+ Diseases as well as Accidents and Suicides



Accidents

Neuropathies
Anemias
Nutritional Deficiencies

Liver Disease
Cirrhosis

Pancreatitis

Suicides
5. Stroke
2. Cancers: Head, Neck, GI cancers

1. Heart Disease:
Cardiomyopathy
Endocartitis
Arrhythmias
Hypertension

Duodenal ulcers

Stomach ulcers
Gastritis

HIV
Hepatitis C

Adapted from: Schuckit MA. In: *Harrison's Principles of Internal Medicine*. New York: McGraw-Hill; 2001:2561-2566.

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In Medicare Administrative Data, Many Comorbid Conditions are More Prevalent Among Beneficiaries with SUD than Beneficiaries without SUD

ICD 10 Category	Condition	Medicare Beneficiaries with a SUD in Past 2 Years	Medicare Beneficiaries without a SUD in past 2 years
Cancer/Neoplasms	Cancer, Colorectal	1.5%	1.2%
	Cancer, Lung	2.2%	1.0%
Endocrine, nutritional and metabolic diseases	Cystic Fibrosis and Other Metabolic Developmental Disorders	1.9%	0.9%
	Diabetes	32.1%	27.5%
	Obesity	27.8%	20.5%
Mental health disorders	ADHD, Conduct Disorders, and Hyperkinetic Syndrome	3.5%	0.8%
	Anxiety Disorders	41.0%	16.4%
	Depression, bipolar, or other depressive mood disorders	40.3%	16.9%
	Personality Disorders	4.5%	1.2%
	Post-Traumatic Stress Disorder (PTSD)	5.6%	0.8%
	Schizophrenia and Other Psychotic Disorders	10.4%	2.1%

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In Medicare Administrative Data, Many Comorbid Conditions are More Prevalent Among Beneficiaries with SUD than Beneficiaries without SUD, Continued

ICD 10 Category	Condition	Medicare Beneficiaries with a SUD in Past 2 Years	Medicare Beneficiaries without a SUD in past 2 years
Infectious Diseases	Human Immunodeficiency Virus and/or Acquired Immunodeficiency Syndrome (HIV/AIDS)	1.2%	0.2%
	Viral Hepatitis	4.7%	0.7%
Injury, poisoning and certain other consequences of external causes	Fibromyalgia, Chronic Pain and Fatigue	46.5%	20.8%
	Traumatic Brain Injury and Nonpsychotic Mental Disorders due to Brain Damage	1.0%	0.4%
	Hip / Pelvic Fracture	1.4%	0.7%
	Spinal Cord Injury	1.9%	0.7%
Diseases of the genitourinary system	Chronic Kidney Disease	36.0%	25.7%
	Benign Prostatic Hyperplasia	9.4%	8.3%
Diseases of the digestive system	Liver Disease, Cirrhosis and Other Liver Conditions	12.3%	4.3%

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In Medicare Administrative Data, Many Comorbid Conditions are More Prevalent Among Beneficiaries with SUD than Beneficiaries without SUD, Continued

ICD 10 Category	Condition	Medicare Beneficiaries with a SUD in Past 2 Years	Medicare Beneficiaries without a SUD in past 2 years
Disease of the nervous system	Migraine and Chronic Headache	7.3%	3.1%
	Multiple Sclerosis and Transverse Myelitis	1.1%	0.5%
	Epilepsy	6.6%	2.4%
	Alzheimer's Disease, Related Disorders, or Senile Dementia	18.4%	11.6%
	Muscular Dystrophy	0.1%	0.1%
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	Anemia	33.6%	21.9%
	Sickle Cell Disease	0.2%	0.0%
	Sensory - Blindness and Visual Impairment	0.8%	0.4%
Diseases of the respiratory system	Asthma	8.1%	4.9%
Diseases of the skin and subcutaneous tissue	Pressure and Chronic Ulcers	9.2%	4.4%

(continued)

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In Medicare Administrative Data, Many Comorbid Conditions are More Prevalent Among Beneficiaries with SUD than Beneficiaries without SUD, Continued

ICD 10 Category	Condition	Medicare Beneficiaries with a SUD in Past 2 Years	Medicare Beneficiaries without a SUD in past 2 years
Congenital malformations, deformations and chromosomal abnormalities	Spina Bifida and Other Congenital Anomalies of the Nervous System	0.3%	0.2%
Diseases of the circulatory system	Atrial Fibrillation	10.5%	9.1%
	Acute Myocardial Infarction	1.6%	0.9%
	Heart Failure and non-ischemic heart disease	23.7%	14.2%
	Hypertension	66.1%	59.4%
	Ischemic Heart Disease	37.0%	27.8%
	Peripheral Vascular Disease (PVD)	20.4%	12.9%
Cerebrovascular diseases	Stroke / Transient Ischemic Attack	5.9%	3.8%
Other	Mobility Impairments	5.8%	2.8%

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Cost Offset Methods:

- Identified subset of conditions where SUD treatment may reduce incidence.
- Used regression modeling and Medicare claims data to measure risk ratios for each of health condition, controlling for age and gender.
- Resulting risk ratios were statistically significant. Ranged from 1.08 to 2.14.
- For example, Medicare beneficiaries 65 + with an alcohol use disorder had 1.58 times the risk of developing Alzheimer's disease or dementia.
- Risk ratios converted to population attributable fractions and SUD-attributable costs to Medicare, representing total Medicare spending attributable to untreated SUDs.
- Assumed a 10-point increase in SUD treatment and that 50% of beneficiaries who receive treatment would relapse.

Cost Offset Methods, Continued

- Estimated the number of new beneficiaries who would no longer use substances
- Estimated decrease in their hospitalized (-22%) or treated at the ED (-29%) for SUDs.
- Multiplied this number by the average price of a SUD-related hospitalization or ED visit.

Limit focus to a subset of conditions that can be caused by SUD and potentially preventable when SUD is treated

- Depression
- Anxiety
- Infectious Diseases (HIV, hepatitis C)
- Cardiac conditions (e.g., atrial fibrillation)
- Bone-related disorders (osteoporosis, hip/pelvic fracture)
- Dementias
- Liver Disease

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Cost Savings from Reduced Incidence of Comorbid Conditions and ED Visits and Hospitalizations

Medicare Spending Changes	Change in Medicare Spending (Range)		
	Per Year	5-Year	10-Year
Cost offsets			
Resulting from reduced incidence of comorbid conditions	-$1,296	-$5,933	-$11,051
Resulting from reduced hospital/ED spending associated with treating SUDs	-$271	-$1,241	-$2,312
Total (b)	-$1,567	-$7,175	-$13,364

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Key Findings

- Net impact on Medicare spending of adding coverage for residential addiction programs, intensive outpatient programs, and licensed and certified counselors:
  - **$362 million per year**
- Cost of adding services to Medicare:
  - **$1.9 billion per year**
- Cost savings from reduced costs from treating medical conditions caused by SUD and from fewer SUD-related hospitalizations and emergency department visits:
  - $**1.6 billion per year**
- Context: Medicare total spending per year
  - $**829.5 billion per year**

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References

- Parish, W. and Mark, T.L. *The Cost of Adding Substance Use Disorder Services and Professionals to Medicare*, August, 2022. https://www.lac.org/assets/files/LAC_Medicare_Budget_Impact_Report_08_08_2022-submitted.pdf

- Mark TL, Parish WJ, Weber EM, Steinberg DG, Henretty K. The cost of opioid use disorder-related conditions in Medicare. Drug Alcohol Depend. 2023 Jan 16;244:109778. doi: 10.1016/j.drugalcdep.2023.109778. Epub ahead of print. PMID: 36701935.

Health Inequities: Age

- As of 2018, individuals under age 65 made up 16.4% of the Medicare fee-for-service population, but made up more than half (51.1%) of Medicare beneficiaries with an opioid use disorder.
- In 2020, Medicare beneficiaries who were 65 and over were 3 times less likely to receive medication for opioid use disorder than beneficiaries under age 65 (8% compared to 25%).
- Adults ages 65 and over had the largest percentage increase in rates of drug overdose fatalities from 2020 to 2021.

Reference #13-14

Health Inequities: Race & Ethnicity

- Black, Indigenous, and people of color (BIPOC) are making up increasing segments of the Medicare population.
- These beneficiaries have more problems accessing medical care and poorer health outcomes than white beneficiaries.
- Half of Black and Hispanic Medicare beneficiaries are enrolled in Medicare Advantage plans (compared to 36% of white beneficiaries), which impose more limitations on access to substance use disorder coverage than traditional Medicare.
- There has been a significant increase in drug overdoses among Black and Indigenous Americans, and they have the highest rates of overdose fatalities.
- Black men over 65 are 7 times more likely to die of an overdose than white men over 65.

Reference #12-15

Health Inequities: Race & Ethnicity

- Black individuals made up 8.8% of Medicare fee-for-service (FFS) beneficiaries, but accounted for 12.1% of Medicare FFS beneficiaries with an opioid use disorder. American Indian/Alaska Native individuals made up .5% of the Medicare FFS beneficiaries, but accounted for 1.1% of those with opioid use disorder.

Race and Ethnicity	% of FFS Beneficiaries	% of those with OUD
Black	8.8%	12.1%
American Indian/Alaska Native	0.5%	1.1%
Hispanic	5.7%	5.7%
White	79.7%	78.9%
Asian/Pacific Islander	2.9%	0.8%

- Access[illegible]% of white beneficiaries with opioid use disorder received MOUD, compared to 15% of Black beneficiaries, 12% of Hispanic beneficiaries, and 10% of Asian/Pacific Islander beneficiaries.

References #10, 13

What Next?

- Proposed rules
  - Greater focus on health equity in Medicare Advantage and across CMS
  - Strengthen network adequacy in Medicare Advantage
    - New standards for substance use disorder and mental health providers
    - Wait time measurements
  - Standardizing coverage criteria in Medicare Advantage
  - Limiting utilization management, including prior authorizations, in Medicare Advantage
  - Improve coverage of medications for opioid use disorder and opioid treatment programs
- Provider and beneficiary outreach on the opioid treatment program benefit and the behavioral health integration benefit
- GAO study on parity in Medicare Advantage

References #4, 6

Policy Recommendations

- Apply the Parity Act to Medicare Parts A, B, C, and D
- Cover licensed and certified substance use disorder counselors
- Cover community-based substance use disorder treatment facilities
- Cover residential treatment for substance use disorders
- Cover contingency management services
- Cover the full crisis continuum for substance use disorder and mental health care
- Address other discriminatory coverage barriers, including:
  - Reimbursement rates for substance use disorder and mental health providers
  - Network adequacy
  - Utilization management and coverage criteria

References #3, 4, 6

Final Takeaways/Summary

- Substance use disorder is becoming increasingly prevalent among Medicare beneficiaries
- Medicare's current coverage is insufficient to meet the needs of beneficiaries with substance use disorders
- Legislative and regulatory reform can continue to improve access to substance use disorder care in Medicare with minimal net cost
- Clinicians can help advocate for these needed changes by sharing their experiences: https://www.lac.org/news/share-your-story-help-us-improve-medicare-coverage-of-substance-use-disorder-treatment

References

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Working with the Opioid Response Network

The SAMHSA-funded ORN assists states, organizations, and individuals by providing the resources and technical assistance (TA) needed locally to address the escalation of opioid, stimulant, and all substance use disorder. No cost TA, education, and training provided by local, experienced consultants in prevention, treatment, and recovery is available by request to help communities in need. Each state/territory has a designated team, led by a regional Technology Transfer Specialist, who is expert in implementing evidence-based practices.

If you have questions, or would like to submit a technical assistance request:

- Visit www.OpioidResponseNetwork.org
- Email orn@aaap.org
- Call (401) 270-5900

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