TRANSCRIPT - Understanding Medicare Coverage for Substance Use Disorder Treatment

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Well, good afternoon and welcome to today's webinar on understanding

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Medicare.

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Coverage for substance use disorder treatment.

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We will get started in just a few minutes, but first,

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A few housekeeping items, all participants entered today's webinar.

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In listen, only mode.

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If you have a question or comments during the call today,

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we just ask that you please type that either into the chat or the Q

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and a box, which should be located at the bottom of your zoom window,

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you may need to hover your mouse around the bottom of the window to

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get the icons to appear.

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So we have some great information to deliver today.

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So without further ado, I'd like to introduce Natalie Tappy.

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She's one of our quality improvement specialists who will introduce

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our guest speaker, Natalie.

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Thank you Mitzi.

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Welcome everyone.

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I would like to introduce our speaker for today.

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Debra Steinberg,

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J D is a health policy attorney at the legal action center.

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Where she advocates for state and federal policies to expand access to

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comprehensive and equity.

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Let's use disorder and mental health care.

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She co-leads the center's Medicare addiction parody project.

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Which seeks to improve Medicare's coverage.

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Of substance use disorder treatment.

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In this role, Debra has testified before Congress.

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Drafted legislation.

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And convened a national learning collaborative.

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To ensure the policies for which she advocates.

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Are rooted in people's.

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Lived experiences.

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She graduated from Vassar college,

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with a BA in psychology and earned her JD from Georgetown university

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school of law.

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So Deborah welcome. And I will turn it over to you.

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Thank you so much.

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I am going to share on screen.

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Wonderful.

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All right. So, yes, my name is Deborah Steinberg.

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I am a health policy attorney.

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With the legal action center.

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Delta be here today to talk to you all about Medicare.

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So just to brief agenda,

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I'm going to give some background about why we're doing this

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initiative.

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Then I'm going to go over what Medicare does cover and what the gaps

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are in substance use disorder treatment.

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And then we're going to go over some policy proposals that we're

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working on to improve access to substance use disorder, treatment,

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and Medicare by changing the coverage policies.

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So some background.

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Why are focused on Medicare? It covers about 62 million individuals.

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A growing number of whom have been diagnosed with substance use

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disorders.

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Medicare is the largest single insurance plan that it's

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not subject to the mental health parity and addiction equity act.

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Which is a non-discrimination law that currently applies to most

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Medicaid and private insurance plans that says mental health and

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substance use disorder.

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Benefits have to be comparable to medical and surgical benefits.

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Medicare also set standards for other texts of insurance,

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like Medicaid and commercial insurance.

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Because those other cans look to Medicare.

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When they're trying to decide how to create policies,

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they look to reimbursement rates,

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they look to network adequacy standards.

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So even when these other plans are subject to the parody act.

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We know that they're actually using some standards that are not parody

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compliant, because they're pulled from Medicare,

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which is not subject to this non-discrimination law.

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When Medicare doesn't have comprehensive coverage,

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it just shifts cost cost to other people in the field.

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It doesn't make the problems go away.

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It just means that the states through their Medicaid or uninsured

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pools or the individuals have to self pay when coverage is inadequate.

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So that's why we're looking at Medicare.

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We worked with some partners to do.

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The prevalence study of what substance use disorder looks like.

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So approximately 1.7 million Medicare beneficiaries.

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How to diagnose substance use disorder as a 2019.

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The rates are even higher in 2020 though.

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It's not a direct comparison because they changed how they were

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measuring some of those conditions.

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And as the 2020 is about 3.4 million people in just 65 and over

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had a substance use disorder.

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And what we know is that only about one in 10 receive any substance

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use disorder treatment and that,

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that number kind of masks what the real problem is because Medicare

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includes both folks 65 and older,

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and also the people under 65 who are eligible due to disability.

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And access to treatment is worse for those over 65 have only about 6%

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of them receive treatment compared to those under 65,

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where it was about 18%.

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And among those over 65.

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I have those under 65.

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Now let's still acknowledge these numbers for under 65 are incredibly

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bad too.

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But what we see is that folks who are under 65 are more likely to also

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have Medicaid. And since Medicaid is subject to the parody act,

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It actually has a bit better coverage than Medicare.

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So that's why these folks have slightly better access to substance use

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disorder treatment.

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And one other point is just, there's a high.

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Co-morbidity a substance use disorder and mental health conditions in

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this prevalence study,

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we saw that Medicare beneficiaries with a substance use disorder are

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more than twice as likely to have past year psychological distress

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than those without substance use disorders.

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And past your suicidal ideation was also significantly higher.

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It's also an issue of racial justice and equity access to substance

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use disorder treatment in Medicare is very inequitable,

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much lower rates of Asian Pacific Islander,

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Hispanic and black beneficiaries are receiving medications for opioid

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use disorder compared to white beneficiaries.

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Medicare beneficiaries are also,

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and then I just kind of break down here a little bit about why that's

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happening, but Medicare beneficiary.

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Who are older are also less likely to receive medications for opioid

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use disorder. And there are some gender disparities as well.

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So let's go into what Medicare covers and what it doesn't.

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We mapped out Medicare's coverage policies to the American society of

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addiction, medicine, continuum of care.

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This reflects that substance use disorder is a chronic condition and

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people will need different levels of care.

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You know,

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at different points and that oftentimes it's more appropriate to step

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up and step down to a slightly more intensive or less intensive level

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of care than just being in treatment or not being intrigued.

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So mapping this out, looking at the first level,

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which is early intervention,

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Medicare does cover a couple of different types of screening for

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substance use disorders,

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including like a basic alcohol misuse screening and counseling.

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Recently,

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it actually started including an annual screening for potential

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substance use disorders in someone's.

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Annual wellness visit.

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And Medicare also recently started covering the initiation of

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medications for opioid use disorder in the emergency room.

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So when someone presents usually with an overdose or other crisis,

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They can now be initiated onto a medication and referred out to

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a provider and can continue that treatment.

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Whoever in that early intervention level,

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Medicare does not cover all of the providers that are typically used

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to treat substance use disorder treatment.

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Medicare does cover psychiatrists.

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It covers psychologists and it covers licensed clinical social

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workers.

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But it does not cover licensed professional counselors,

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licensed and certified substance use disorder counselors.

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Those are also known as addiction counselors.

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Or alcohol and drug counselors,

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and Medicare does not cover peer support.

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Specialists.

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So this,

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this gaps in providers actually prevents some of these things that

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are.

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Supposed to be covered like spurt and alcohol misuse screening from

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actually being effectively delivered because these are the folks that

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are sometimes if not often providing these early intervention

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services.

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Looking at Eastern level one.

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Medicare does cover counseling and treatment and offices and hospital

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outpatient departments.

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There's a relatively new.

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Bundled payment for office based counseling and care management.

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It's not being used a ton yet, but it's new.

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So we're stopped domestic.

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Recently also started covering opioid treatment programs. Again,

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new could be utilized more, still optimistic,

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and Medicare actually has pretty good coverage of tele-health for

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substance use disorder treatments.

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One of the few places where it's allowed to be in the home,

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it's allowed to be regardless of your geographic location,

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you don't have to be.

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On like a remote or rural area.

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And most recently it's allowed to be audio only.

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We have the same issues with providers not being covered.

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These are the folks that do most of the counseling. So again,

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even though we have coverage of a service,

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it's not effectively able to reach all of the Medicare beneficiaries.

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Another problem that starts to come up with outpatient services is the

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settings. So community-based substance use disorder.

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Treatment facilities are some of the most common places where people

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go for treatment.

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It's where a lot of the addiction treatment providers are.

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And these specific.

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These cannot independently, bill Medicare.

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So they're unable to take on most Medicare patients.

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For ACM level two, there are two types of care.

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There's intensive outpatient programs,

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which is nine to 19 hours of different therapies per week.

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And then there's partial hospitalization programs,

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which are 20 plus hours a week.

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The partial hospitalization programs are covered,

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but only if it's out.

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In a hospital or a community mental health center that is not

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typically where a substance use disorder,

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partial hospitalization programs happen.

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So it means that essentially no one is getting coverage for a

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substance use disorder, partial hospitalization program.

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The exception to that is there are some places that do

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pressurization programs,

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where people who are dually diagnosed with substance use disorders and

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mental health condition. So there's kind of a slight way in.

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It'll make your primary diagnosis as a mental health condition.

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And then there's no coverage for intensive outpatient programs.

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So the 1919 hour programs.

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Moving on to residential treatment, there are four different levels.

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Medicare does cover the highest level of three seven.

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If it's an inpatient setting,

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Medicare does not cover levels 3 1, 3, 3 or three five,

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and those levels just reflect what the mix and breadth of those

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services are that are being provided.

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And same issues with the missing providers and missing settings.

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And level four,

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Medicare does cover hospital-based intensive inpatient substance use

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disorder treatment.

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It does not cover all of the providers that are going to be inside a

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hospital.

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That being said most of these hospitals can bill for those providers

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under incident to billing.

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Some of them just don't or they don't hire people because they don't

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know how to do that. Fillings. There are still some barriers there.

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And then there's also 190 day lifetime limit on inpatient psychiatric

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treatment.

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No such lifetime limit for medical surgical treatments.

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So it's just discriminatory and incredibly problematic.

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Withdrawal management is also something that is covered in Medicare,

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but really only in an office or hospital-based settings.

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So we're missing the folks who typically get withdrawal management in

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those intermediate levels of care that are not covered.

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Still missing the provider's done missing the settings.

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Then two other things to flag Medicare does not cover the full crisis

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continuum.

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So when we think of that, that's, you know,

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someone to call some one to come somewhere to go Medicare

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doesn't do any of those things. So people in crisis are, you know,

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subject to usually very high astronomical costs when they need

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treatment. You know,

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that that doesn't include it like an emergency room and emergency

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service. This is more like crisis urgent care.

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And then Medicare also doesn't cover contingency management,

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which is one of the only evidence-based treatment models for folks

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with stimulant use disorder.

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So it's just something that we're advocating on,

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recognizing that there is a growing number of folks who are being

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diagnosed with.

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Methamphetamine use disorders, things like that.

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Some other barriers to care, insufficient access to providers,

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reimbursement rates are Bismol.

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Discriminatory rates.

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I think practices are being used because Medicare is not subject to

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the parody act.

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They're really limited networks and substance of substance use

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disorder and mental health providers. We see the seven part C plans.

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People can't find a provider within a reasonable time and distance.

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And a real shortage of culturally effective substance use disorder

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providers.

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This is supplies when we're thinking about like linguistic and

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culturally competent providers. So BiPAP providers,

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but also.

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You know, providers that actually specialize in older adults,

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there's just a shocking.

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Dearth of them in our, in our society right now.

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So we need more training.

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We need more programs that are born encourages folks into the

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workforce, but frankly,

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we're approaching this from the Medicare insurance angle because

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that's how you really get things covered.

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If these are covered by insurance and reimbursable.

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You'll actually start seeing them in your society.

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There's a lack of standardized medical necessity criteria.

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We have no idea what most Medicare advantage plans are using when they

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decide if something's worth treating or not.

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And they won't give us a, when we do ask for it.

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They use really stringent utilization management practices like

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excessive prior authorizations and concurrent reviews.

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Tele-health limitations.

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There are still a couple of kinks for trying to work out.

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Allowing the audio only for example is only through regulations.

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It's not in statute.

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We do not want a future administration to reverse that.

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And then there's just really broad custody,

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exclusion that basically we know that Medicare and

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Medicaid also don't pay for treatment when you're in jail or prison

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when you're incarcerated. But for Medicare.

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They also extend in custody to people that are like out in the

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community on a bail or parole.

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Which makes no sense because they're not actually in custody,

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so they're not getting their treatment paid for by anyone else.

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So it's just something that interferes with people's access to care.

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So, what are we doing about it?

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We are working to amend the social security act because a lot of these

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things need to be done in statute.

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So we want Medicare to cover the full continuum of substance use

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disorder treatment. So all those intermediate levels of care,

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we don't think it should just be some outpatient counseling and some

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hospital treatment because that's not meeting people's needs.

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That's not reflecting how treatment is delivered.

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Or how people need treatment.

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So you need those intermediate levels of care covered because this

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means people can step up appropriately and it means they can step down

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at birth, really. So we need ILPs,

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PHPs and residential treatment covered.

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We'd also like to see those crisis services covered and contingency

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management.

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We're also working to make sure that Medicare covers the full range of

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provider types that make up the addiction treatment workforce like

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licensed professional counselors,

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licensed and certified substance use assertive counselors and peer

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support specialists.

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We also want Medicare to cover community based substance use disorder,

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treatment facilities that are providing most of these services.

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And frankly employ a lot of these professionals.

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We're also hoping to apply the parody act to Medicare.

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And to explain a little bit about what that would look like,

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because it's not just a name. We want Medicare not to discriminate.

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So one of the rules about the parody act is it says you cannot have

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coverage exclusions.

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The paradox, classifies all services into different categories.

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There's inpatient treatment,

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outpatient emergency and prescription drug.

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So mental health and stuff,

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since you started benefits are provided in one of those categories.

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So if you provide inpatient mental health and substance use disorder

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treatment,

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And you have to provide benefits in all of the classifications.

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Does that means it ensures that we get prescription jobs and shows we

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get all the different levels of intermediate outpatient levels of

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care.

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It also means that if services are available for medical and surgical

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conditions, such as residential rehab for a physical injury,

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like in a skilled nursing facility,

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Then comparable services must be available for mental health and

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substance use or conditions like residential substance use disorder

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treatment.

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It also means you can't impose other barriers that would exclude

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coverage or severely limited such as excluding the providers and the

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settings that deliver care.

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So some of these things do have to be coupled with actually expanding

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the statute. We have to actually go in and say,

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Medicare covers these providers.

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But even if that doesn't work,

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we have this leverage in once we apply the parody act to Medicare,

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because it is part of the parody act.

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You just kind of have to do both and we don't want to have to do it

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twice. We're trying to do it all at once.

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It prevents Medicare from having quantitative or frequency

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limitations.

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So the parody act would help us eliminate the 190 day lifetime limit

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on inpatient psychiatric hospital stays.

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There are requirements related to parody for network adequacy.

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So this again, mostly affects Medicare advantage plans.

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It means that they would have to use comparable and no more stringent

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criteria for network admission and credentialing providers of mental

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health and substance use disorder services than what they use for.

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Medical and surgical providers and same goes for reimbursement rates.

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So we're hoping that will help elevate reimbursement rates a little

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bit and make it actually a living wage.

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Same goes for utilization management, prior authorizations,

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getting authorization, step therapy, dosage, limitations,

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all sorts of things like that.

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After be comparable and no more stringent.

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For mental health and substance use disorder.

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They are for medical and surgical benefits.

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Then all the other things I've mentioned when I was talking about some

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of those other barriers to care,

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those are things that we're trying to do with the centers for Medicare

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and Medicaid services. So the earlier stuff,

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I just mentioned that stuff we're trying to do through legislation

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with Congress.

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These are some things we're trying to do directly through CMS.

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So requiring standardized medical necessity criteria that are based in

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evidence and generally accepted standards.

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Establishing reimbursement levels that are adequate for the different

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Eastern levels of care.

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Eliminating discriminatory utilization management practices,

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like not real medical necessity criteria or characterizations,

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lemming, discriminatory, reimbursement rate, rate, setting,

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making those tele-health flexibilities, permanent.

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Some other things that we've seen that we want to keep.

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Requiring network adequacy standards and reporting for substance use

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disorder providers and eliminating that custody solution for

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beneficiaries in the community.

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One of the other things that we're doing to help with our advocacy,

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both at the federal,

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and we'll do the congressional and regulatory level or collecting

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stories from people around the country with lived experiences.

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So we've heard from a number of folks.

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We shared their stories when they give us permission to do so often

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anonymized.

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So that legislators know that this is affecting their constituents and

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they can see how it's actually impacting people on the ground.

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We also are partnering with advocates in a number of states that are

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willing to send letters to their delegation.

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So we had some folks in Texas draft a letter and they got 75 different

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providers ranging from like large providers to, you know,

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a counselor that practices on their own,

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who all talked about why this was important to them and their state,

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how it shifts cost to the state and the harm it has to, to their.

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You know, to the legislators constituents when,

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when we don't have parody and Medicare.

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So the good news is we're making progress.

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Our advocacy is kind of working.

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The president in his FYI 20.

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And trying to do budget called for application of the parody,

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act to Medicare as well as expansion of provider types and eliminating

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that one 90 days. Psychiatric inpatient limit.

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Multiple congressional committees.

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Hustlers and means Senate finance,

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energy and commerce also have held hearings on how to improve

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Medicare's coverage of mental health and substance use disorder

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treatment.

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And they're all flagging the parody act.

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I finance committee recently.

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He released a report.

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Which highlighted similar recommendations and cited our review of

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Medicare's gaps.

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And then the GAO,

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the government accountability office recently released a report as

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well, that identified.

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Many of these barriers to care.

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So there's a lot of attention around this right now,

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and we're really hoping that we can keep this momentum going and get

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some legislation and new rights through to really make a difference.

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Here's some resources I'll make these all available to folks after the

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call.

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And just thank you.

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My contact information is here as well as my colleague who co-leads

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this project with me, Alan Webber.

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And I'm happy to answer any questions in the timer. Meet.

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I thank you so much, Debra.

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Just wanted to remind everyone, if you have a question for Debra,

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go ahead and enter that into the chat or the Q and a box at this time.

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Let's see.

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Debra. One of the questions that I see it says our Medicare.

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Advantage plans doing any better?

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At covering SUD treatment.

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And how would these policy proposals affect.

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Medicare advantage plans.

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Yeah. Great.

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So we were kind of optimistic when we started this project, you know,

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Medicare advantage plans can offer supplemental benefits.

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We found that in the substance use disorder field, they're not,

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we have not found any of them that are actually offering any of the

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supplemental benefits that we've identified as missing.

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They're not doing any better at covering, you know,

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facilities or providers either.

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Well,

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we are seeing instead is that they're imposing more barriers to care.

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So when I talked about utilization management,

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We see that interfering with care a lot more for people than Medicare

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advantage plans. So we heard from some folks who, you know,

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went inpatient, they went to a hospital that is a covered benefit.

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And their Medicare advantage plan would require their provider to

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submit a reauthorization for treatment every single day or maybe

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every other day.

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And rather letting them stay as long as they need to stay in

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treatment.

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They end up cutting off the treatment earlier either because of this

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huge paperwork burden for providers, or they say after, you know,

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three days, four days,

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maybe even 10 days that it's no longer medically necessary.

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Even when the doctor is saying this person is still in crisis,

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they still need this level of care.

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So it's preventing folks from getting the treatment that they need is

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preventing them from staying in the level of treatment that they need.

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It just creates a gap in or delay. And when they,

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when they say they need treatment,

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when they're willing to get treatment and when they're actually able

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to get it, which as we know in the substance use disorder field,

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that can mean life and death. We heard from folks that.

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You know, the authorization took three or four days to get through.

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And then by the time that family member was still trying to get

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treatment for their son,

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that son was no longer willing to enter treatment.

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We heard other folks who ended up in jail because of treatment delays

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or because provider networks were inadequate and they were unable to

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get access to care in a timely manner or, you know, within.

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Hours of their home.

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So we see this as,

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as sadly a much bigger issue in Medicare advantage plans,

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which we know is a rising number of people who are in Medicare.

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And it's,

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it's a disproportionately high number of black and brown individuals.

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About half of Medicare beneficiaries who are black and brown are in

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Medicare advantage plans.

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That's a much higher rate than white beneficiaries.

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So we see not only the disproportionate policies,

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but we see like a really disproportionate effect on beneficiaries as

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well.

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Thank you.

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Debra.

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I see another question.

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Are there any concerns that policymakers have raised to these

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proposals and how are you addressing them?

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Yeah, thank you. So we here,

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people are concerned about the cost that always happens when you're

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trying to change Medicare,

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you may be familiar with concerns about like the hospital trust fund.

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And just.

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Certain legislators don't want to spend money on Medicare

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beneficiaries, which is really sad.

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There's still a lot of stigma about substance use disorders.

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And people don't think it's something that we should be paying for.

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So we're doing a lot of education where we're really trying to explain

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what this treatment looks like.

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We're sadly trying to explain basic human rights to healthcare,

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and that everyone deserves to get treatment and ask for the cost.

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We are working with the health economist,

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who did our prevalence study to make the case for why this is

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cost-effective.

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So the next study we're doing with them is looking at the

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comorbidities associated with opioid use disorder in particular we're.

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Looking at which conditions are often exacerbated by untreated

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substance use disorder to show how treating people's substance use

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disorder will actually help with overall health care costs, you know,

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because actually substance use disorder treatment,

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not as expensive compared to a lot of these other treatments that

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we're talking about here.

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But then even for the cost of substance use disorder treatment,

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we're also going to be doing a study with them to show what the cost

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would be of adding these benefits that we talked about,

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and also what the cost savings would be.

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Because when we're talking about these intermediate levels of care,

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We're actually talking about keeping people out of the hospital or

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getting them out earlier because they can be safely discharged to a

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step down program that's in their community and lower cost.

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We're also preventing friction getting into the hospital in the first

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place because those intermediate levels of treatment are available,

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which are often more appropriate.

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People don't necessarily need to be in the hospital.

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Medically monitored, 24 7.

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But also once a week, outpatient treatment isn't enough.

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So some of those three day a week programs are probably perfect for a

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lot of these people. So if we can get them out of the hospital,

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We are saving money.

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So we're making that argument to policymakers.

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The question is whether CVO,

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the person who actually decides what the score of ability,

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whether they will listen, that's a little bit hit or miss, but.

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People do understand when we talk about this continuum and how we only

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cover the bookends of treatment, it's missing the mark.

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And they do understand that substance use disorder,

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mental health conditions don't go away.

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When you turn 65 and having policies that treat people as though

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they're conditions will just go away is not helpful.

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It's just discriminatory. And it, it hurts our families.

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It hurts our communities and it hurts our society.

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And we can do a lot better.

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Thank you so much, Debra.

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It looks like one last question and it's just simply asks,

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what can we do to help?

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Yeah, that's great.

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If you are interested in, you know, sharing his story,

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if you know someone who has been affected by this, if you see this,

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you know, at all in your lives.

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We actually,

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we have had people from Medicare advantage plans have filled out our

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survey, which I think is kind of hilarious.

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Like the people who work for them, not people in them.

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And they're like,

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I was actually trying to help one of my best beneficiaries get

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treatment. And I couldn't because this level of care isn't covered.

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I was like, yeah, you can, you can do that yourself.

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You don't need Congress to do it, but that's great.

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Glad you're paying attention.

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So,

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so hearing from anyone who has these experiences is really helping us

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flush out and understand what's happening.

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It's really helpful for legislators and policy makers to hear how this

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is impacting people on the ground.

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So that makes a big difference.

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You can either share it with us through.

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Our story length that we'll share afterwards.

00:28:06.000 --> 00:28:07.000
Or telling your Congress,

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people tell your legislators that this is important to you. That it's.

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You know,

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harming our communities that we're not treating people aged 65 and

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over and younger folks with disabilities that we're not treating them

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fairly,

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that we discriminate against them because they have mental health and

00:28:24.000 --> 00:28:25.000
substance use disorder conditions.

00:28:25.000 --> 00:28:27.000
Make your voice heard on this, your,

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your legislators actually do want to hear from you and they want to

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make a difference for people in their community.

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And so if they know it's impacting you, they will,

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they'll take a stand on this. We have,

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we have some really good policymakers who are working with us.

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On this already. It's it's on the table. Everyone's talking about it.

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So have your voice be a part of that conversation?

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And let me know how I can help,

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where we work closely with states and with coalitions when they're

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putting together letters or when they're trying to get involved.

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And we can share those drafts and templates with you.

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So you don't have to start from scratch.

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You know, you don't need to reinvent the wheel.

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We know what's working and we want to continue doing it.

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So thank you so much.

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I thank you so much, Debra.

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And that looks like all the questions that we have. If.

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We really appreciate your time today and the information that you

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provided.

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If you have any closing remarks that you would like to say,

00:29:18.000 --> 00:29:20.000
or Natalie, if you want to make any closing remarks.

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On behalf of quality insights, please go ahead.

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Just thank you for all the work that you all do to improve access to

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care and to improve the quality of care for people in Medicare and all

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other types of insurance. It's wonderful.

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And I am really grateful to be here. Thank you.

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You Deborah.

00:29:44.000 --> 00:29:45.000
For joining us.

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I can't wait to get the slides to put on our website if that's okay.

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You know, resource library.

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So those will be available.

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Two.

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Everyone.

00:29:52.000 --> 00:29:53.000
But again, I thank you.

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For taking time to meet with us today.

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All right. Well, with that, we will conclude today's webinar.

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This,

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the recording and the slides will be available on the website that I

00:30:09.000 --> 00:30:11.000
posted in the chat.

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And hope that everyone has a wonderful afternoon. Again,

00:30:14.000 --> 00:30:16.000
thank you Deborah. For your time.