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Medicare Coverage of Opioid Addiction Treatment Services

Medication-Assisted Treatment (MAT) combines medications, with counseling and behavioral therapies to provide a holistic approach to treating substance abuse. The federal government has taken steps to increase the availability of MAT in response to a sharp increase in U.S. opioid overdoses and deaths in recent years. Medicare beneficiaries may have difficulty gaining access to comprehensive MAT services, however, due to coverage limits in the federal health care program.

Medicare does not have a distinct benefit category for substance abuse treatment, although the program pays for certain services deemed reasonable and necessary for treatment of alcoholism and opioid abuse when provided in settings certified by the Department of Health and Human Services (HHS). For example, Medicare does not cover MAT provided in federally registered opioid treatment programs (OTPs or methadone clinics). Medicare may pay for MAT drugs and counseling in other certified care settings but coverage may be limited, enrollees may face interruptions if they move between care settings, and cost-sharing may vary. Congress and the Trump Administration are considering proposals for broader Medicare MAT coverage, such as a bundled provider payment for a set of defined services and reimbursement for OTPs. This brief provides background on MAT and Medicare policy.

How Does MAT Work?

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), MAT can provide a safe and controlled level of medication to help patients overcome opioid abuse. Research indicates that MAT is most effective when it combines drug therapy with behavior treatments and cognitive therapy (to challenge individual thought patterns). MAT may be provided in an inpatient hospital or treatment program; in the roughly 1,500 OTPs in the United States; and, in certain cases, by specially trained physicians or health care providers outside of OTPs.

The Food and Drug Administration (FDA) has approved three medications for treating opioid dependence: methadone, buprenorphine, and naltrexone. Methadone and buprenorphine, which are opioids with the potential for dependence, also may be prescribed for the treatment of pain, outside of MAT. The drugs used in MAT may help to stabilize brain chemistry, reduce or block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions. Experts recommend that all three drugs be available to people in MAT because certain medications may be more appropriate for some patients.

Methadone and buprenorphine are regulated under the Controlled Substances Act (CSA; 21 U.S.C. §§801 et seq.). Under the CSA, methadone may be used to treat opioid addiction within an inpatient setting, such as a hospital, or in an OTP. An OTP may administer or dispense, but not prescribe, methadone (see **Table 1**). Buprenorphine also may be dispensed through an OTP. In addition, the Drug Addiction Treatment Act of 2000 (DATA 2000; P.L. 106-310) allows physicians and certain other health care practitioners to obtain waivers to treat opioid addiction with buprenorphine (but not with methadone) outside an OTP in inpatient and outpatient settings. The FDA approved an implantable version of buprenorphine in May 2016 that lasts for three months, and an injectable version in November 2017 that lasts for a month. The drug may also be dispensed in other forms through a retail pharmacy.

Naltrexone, which is not an opioid, does not carry an addiction risk and is not regulated under the CSA. Naltrexone may be used in an OTP, or may be provided outside an OTP by health care professionals who are allowed to prescribe drugs, without federal DATA waivers.

Table 1. Allowable Provision of MAT Drugs

Medication	Providers Authorized to Provide Drugs		
	OTPs	Data Waiver Prescribers	Other Prescribers
Methadone	Yes	No	No
Buprenorphine	Yes	Yes	No
Naltrexone	Yes	Yes	Yes

Source: CRS analysis based on 21 U.S.C. §801.

Opioid Use in Medicare

The federal Medicare program provides health coverage for qualified individuals age 65 and older and individuals with permanent disabilities. The program is expected to serve 60 million elderly and disabled in 2018. Medicare benefits are provided through Part A, which covers hospital (inpatient) services; Part B, which covers physician services and other outpatient care; Part C, a managed care option that covers Part A and B benefits (except hospice care); and Part D, a voluntary program that provides coverage of outpatient prescription drugs through private health plans.

Opioid overutilization is a significant issue in Medicare. A November 2017 report by the HHS Office of Inspector General (HHS OIG) found that one in three Part D enrollees received an opioid prescription in 2016 (14.4 million out of 43.6 million enrollees). Nearly 500,000 Part D enrollees received what the HHS OIG termed high levels of opioids (a 120 morphine milligram equivalent [MME] average dose for at least three months), a figure that did not include Part D enrollees with cancer or in hospice care. A MME measures the cumulative use of opioids over a 24-hour period.

The Centers for Medicare and Medicaid Services (CMS) operates a Part D opioid overutilization monitoring system (OMS) to prevent abuse of prescribed opioids in Part D. Because there are often no set, maximum dosage limits for opioids, CMS has developed its own dosage and other thresholds to identify potential overutilization. The most recent CMS thresholds are based on 2017 opioid prescribing guidelines by the Centers for Disease Control and Prevention. Under the OMS program, Part D plans review and provide case management for at-risk enrollees. (The policy excludes individuals in hospice or cancer treatment.) MAT drugs are not counted in OMS dosage criteria. Starting in 2019, Part D plans may limit the number of prescribers and pharmacies used by enrollees at risk of overutilizing commonly abused drugs.

Medicare Coverage of Substance Abuse Services

Medicare currently covers MAT as a series of discrete services, rather than as an integrated program (**Table 2**).

Medicare Part A covers inpatient services for substance abuse at a qualified hospital or psychiatric hospital. (Medicare A pays up to 190 days of inpatient psychiatric hospital services during an enrollee's lifetime.) Part A covers approved medications when used for inpatient treatment. Beneficiaries pay applicable deductibles and copayments.

Medicare Part B may cover MAT-related services in approved outpatient settings such as community health centers or physicians' offices. Part B covers physician and professional services and may also cover psychiatric services (partial hospitalization services) including therapy, drugs, and counseling. Enrollees pay a deductible and 20% coinsurance for Part B services.

Part B may cover outpatient MAT drugs for opioid withdrawal when administered by an approved provider, such as a physician with a DATA waiver who participates in Medicare. Medicare generally reimburses physicians and other providers for covered Part B drugs at 106% of the volume-weighted average sales price. Medicare pays providers separately for the administration of most Part B drugs. Since January 2018, Medicare Part B has covered the insertion and removal of buprenorphine implants. Medicare statutes do not recognize OTP clinics for reimbursement. Because methadone for MAT may be provided only in OTPs, it is *not* covered by Part B.

Medicare Part D plans cover outpatient drugs that may be dispensed in a retail pharmacy upon a prescription for a medically accepted indication. Part D plans may cover methadone when prescribed for pain. Because methadone used for outpatient MAT may be dispensed only in an OTP clinic, it is *not* covered by Part D.

Medicare Part D plans must cover other self-administered MAT drugs, either on their formularies (list of covered drugs) or via a coverage exception request by an enrollee. Part D plans also must provide a transition supply of MAT drugs for new enrollees who are already in treatment. While HHS may not set a central Part D formulary, each Part D plan must cover at least two drugs in each class and category. CMS in guidance has said it will not approve Part D formularies that discourage enrollment by patients who require MAT. CMS expects Part D sponsors to set low cost-sharing for MAT drugs, and to impose prior authorization (PA) requirements (plan approval before dispensing a prescription) no more than once a year. Still, there is variation in cost-sharing and other requirements for MAT drugs among Part D plans.

Medicare Part C plans must cover the Parts A and B components of MAT and may offer Part D coverage. Although Medicare does not cover methadone for MAT under Parts B or D, a Part C plan may cover methadone for MAT as a supplemental benefit—meaning a benefit that is not otherwise covered by Medicare.

Table 2. Medicare Coverage of MAT Services

Part A	Inpatient counseling and drugs for covered stay in a Medicare-approved hospital or in-patient facility.
Part B	Outpatient counseling, physician services, and MAT drugs not usually self-administered, including some forms of buprenorphine, furnished in a Medicare-approved facility. Methadone is not covered because Medicare law does not recognize OTPs as providers.
Part D	MAT drugs dispensed by a retail pharmacy via prescription. Methadone for pain may be prescribed and is covered by Part D. Methadone for MAT may be dispensed—not prescribed—and is not covered.
Part C	Required A and B services, and Part D services if plan includes drug component. Methadone may be covered as a supplemental benefit.

Source: CRS table based on CMS data.

Medicare MAT Reimbursement Proposals

House and Senate committees have held a series of hearings during the 115th Congress to examine Medicare coverage of MAT services. Lawmakers have introduced various pieces of legislation to create a Medicare MAT bundled payment for providers, which would cover a comprehensive suite of services. Medicare-covered services could include such things as patient intake and assessment; counseling and medical care; and administration of medication and patient monitoring. Some of the bills would expand Medicare reimbursement to OTPs, including coverage of methadone. Among the bills are H.R. 5083 and H.R. 5080.

The Trump Administration's FY2019 budget proposal calls for a demonstration program to test the effectiveness of providing Medicare bundled reimbursement on a per-week-per-patient basis to MAT providers. The pilot program would recognize OTPs and substance abuse treatment facilities as independent provider types for Medicare reimbursement. Outpatient counseling services would be billed separately, as necessary. The pilot could be targeted at Medicare enrollees identified as at-risk through the OMS, and could be expanded nationwide if found to be effective.

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