LEGAL ACTION CENTER

Board of Directors

Brad S. Karp
Chairman

Mary Beth Forshaw
Vice Chair

Lymaris Albors
Gerald Balacek
Eric D. Balber
Elizabeth Bartholet
H. Westley Clark
Suzanne B. Cusack
Jason Flom
Alexis Gadsden
Jeffrey D. Grant
Tony Lee
Doug Liman
Ann-Marie Louison
Ross A. Lovern
Elaine H. Mandelbaum
Kamran Masood
Mark C. Morril
Mary E. Mulligan
Danielle Nicosia
Debra Pantin
Elizabeth M. Sacksteder
Sharon L. Schneier
Virginia Sloan
John J. Suydam
Harya Tarekegn
James Yates

Arthur L. Liman
Founding Chairman

Daniel K. Mayers
Chairman Emeritus

Executive Team

Paul N. Samuels
Director & President

Sally Friedman
SVP of Legal Advocacy

Tracie Gardner
SVP of Policy Advocacy

Ellen Weber
SVP for Health Initiatives

Gabrielle de la Guéronnière
VP of Health & Justice Policy

Roberta Meyers Douglas
VP of State Strategy & Reentry

Adela Prignal
Chief Financial Officer

Sharon X. Hayes
Director of Operations

Sarah Nikolic
Sr. Director of Program Support

Testimony of Deborah Steinberg, J.D.
Senior Health Policy Attorney
Legal Action Center

Submitted to the
Senate Special Committee on Aging
December 14, 2023

Chairman Casey, Ranking Member Braun, and Members of the Senate Special Committee on Aging,

Thank you for the opportunity to testify today on Legal Action Center's work to improve access to substance use disorder treatment for older adults. The Legal Action Center is a non-profit law and policy organization that fights discrimination, builds health equity, and restores opportunities for people with substance use disorders, arrest and conviction records, and HIV/AIDS. We lead the Medicare Addiction Parity Project and, with our partners at the Center for Medicare Advocacy and the Medicare Rights Center, seek to achieve comprehensive and equitable substance use disorder coverage in Medicare.

SAMHSA's National Survey on Drug Use and Health (NSDUH) data reveal that approximately 4 million adults ages 65 and older had a substance use disorder in 2022, representing about 7% of the population.[1] About 1.4 million older adults received treatment that year.[2] Recognizing that financial barriers have been one of the most commonly reported reasons for older adults not receiving treatment,[3] we commend Congress and the Centers for Medicare & Medicaid Services (CMS) for their work over the past few years to increase Medicare coverage of substance use disorder treatment in an effort to address this problem. Such work has laid a strong foundation to improve access to substance use disorder care for older adults. Nonetheless, there are still outstanding gaps and barriers to substance use disorder care in Medicare that we recommend Congress address.

Medicare Coverage and Recent Improvements

Substance use disorders are chronic conditions that are treated along a continuum of care. Historically, Medicare has only covered the least and most intensive services, essentially requiring older adults to wait until their conditions become acute before they could get treatment. The lack of coverage of intermediate levels of care also prevented individuals from being able to discharge and step down safely from

[1] SAMHSA, "2022 National Survey on Drug Use and Health," Tables 5.3A & 5.3B (2023), https://www.samhsa.gov/data/report/2022-nsduh-detailed-tables.
[2] *Id.* at Table 5.14A.
[3] William J. Parish et al., "Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers," Am. J. Prev. Med. (Mar. 21, 2022), https://pubmed.ncbi.nlm.nih.gov/35331570/.

inpatient care to reenter their communities with the appropriate treatment and supports they need. Furthermore, the lack of readily available and appropriate care in the community is a disincentive for practitioners to screen for and intervene with older adults who may have or be at risk for a substance use disorder, and likely contributes to the low level of treatment engagement.

As a result of Congress's passage of the SUPPORT Act of 2018, Medicare began to cover opioid treatment programs in 2020, which has greatly expanded access to medications for opioid use disorders (MOUD), particularly for Black and brown beneficiaries. At the same time, CMS also developed a bundled reimbursement code for office-based substance use disorder treatment. However, the Office of Inspector General has reported that access to MOUD is still inadequate, and it remains lower for older adults, people who are not receiving financial assistance, and Black, Hispanic, and Asian/Pacific Islander beneficiaries.[4] These disparities are particularly concerning as the rate of overdose deaths for older adults has quadrupled over the past two decades,[5] where Black men over the age of 65 are seven times more likely to die from an overdose than white men in the same age group.[6]

We commend Congress for passing the Consolidated Appropriations Act (CAA) of 2023, which closed several more significant gaps in substance use disorder treatment. For example, Medicare will now cover intensive outpatient (IOP) services beginning January 1, 2024. IOP is for patients who need a minimum of 9 hours of therapy, but no more than 20 hours, and will be reimbursable in hospital outpatient departments, community mental health centers, federally qualified health centers, rural health clinics, and opioid treatment programs. The IOP benefit, which builds on the existing and more intensive partial hospitalization (PHP) benefit, will be available in far more community-based settings than PHP and, appropriately, does not require the beneficiary to otherwise need to be hospitalized. In the final CY24 Outpatient Prospective Payment System (OPPS) rule, CMS clarified that both IOP and PHP are available for Medicare beneficiaries with a mental health *or* a substance use disorder diagnosis, and that services may be delivered by mental health *or* substance use disorder professionals. Nonetheless, there are still several statutory barriers that prevent these levels of care from being truly available to beneficiaries with substance use disorders.

Congress also significantly expanded the workforce by authorizing mental health counselors and marriage and family therapists to treat Medicare beneficiaries with substance use disorders and mental health conditions as of January 1, 2024. In the CY24 Physician Fee Schedule (PFS) final rule, CMS defined the term "mental health counselor" broadly to include licensed and certified professional counselors, addiction counselors, and alcohol and drug counselors – or other practitioner titles used by states – who (1) have a master's or doctorate degree in counseling, (2) are licensed or certified by the state in which they furnish services, and (3) have performed at

---

[4] U.S. Department of Health & Human Services, Office of Inspector General, "Many Medicare Beneficiaries Are Not Receiving Medication to Treat Their Opioid Use Disorder" (Dec. 2021), https://oig.hhs.gov/oei/reports/OEI-02-20-00390.pdf.

[5] Keith Humphreys & Chelsea Shover, "Twenty-Year Trends in Drug Overdose Fatalities Among Older Adults in the US," JAMA Psychiatry (Mar. 29, 2023), https://jamanetwork.com/journals/jamapsychiatry/article-abstract/2802945.

[6] Centers for Disease Control & Prevention, "Overdose Death Rates Increased Significantly for Black, American Indian/Alaska Native People in 2020" (July 19, 2022), https://www.cdc.gov/media/releases/2022/s0719-overdose-rates-vs.html.

least 2 years or 3000 hours of supervised clinical experience after obtaining their degree. The American Counseling Association estimates that approximately 200,000 new counselors will be eligible to enroll in Medicare as a result of this rule.[7] While we are optimistic that counselors will enroll, one outstanding concern that may limit uptake is that these new practitioners, like clinical social workers, will only be reimbursed at 80% of the lesser of the actual charge or 75% of the PFS rate for psychologists (compared to 85% for medical non-physician practitioners), and they may not separately bill for services in skilled nursing facilities.

People with lived experience can provide invaluable assistance and support to Medicare beneficiaries with substance use disorders to help address issues that often create barriers to care. While CMS does not have the statutory authority to allow peer support specialists and community health workers to bill Medicare, it took the initiative to develop new service codes – community health integration (CHI) and principal illness navigation (PIN) – that will allow these individuals to address the social determinants of health (SDOH) needs of Medicare beneficiaries while working under the supervision of certain Medicare providers. Billing practitioners can partner with community-based organizations that employ peers and community health workers to help meet their patients' needs, as supervision for these services does not need to be on site. We recommend Congress adopt a definition of peers in Medicare statute and identify the other settings and services in which peers contribute to the treatment teams.

The CY24 PFS rule also recognizes the increased cost of service delivery for individuals with complex substance use disorders and the historical undervaluing of those services in Medicare reimbursement rates. To begin to address reimbursement barriers to provider participation in the Medicare program, CMS has increased the reimbursement rates for a number of substance use disorder and mental health services, including psychotherapy codes, behavioral health integration codes, and the bundled office-based substance use disorder codes (G2086-G2088). While CMS appropriately recognizes the need to address the low Medicare reimbursement rates, much greater rate increases and structural reform are necessary to meet the demand for substance use disorder and mental health services and close the discriminatory reimbursement gap between these and medical services.

Recommendations

These improvements will certainly help save lives, but there is more that Congress must do to improve access to substance use disorder treatment for older adults.

A. Remove Discriminatory Standards in Medicare

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

Older adults and people with disabilities deserve non-discriminatory coverage of substance use disorder and mental health treatment. Remarkably, the Medicare program – the standard-setter for other types of insurance – is the largest health care financing program that is not subject to

[7] American Counseling Association, "Medicare Law Passes: FAQs on the Passage of the Mental Health Access Improvement Act" (2023), https://www.counseling.org/docs/default-source/government-affairs/faqs-on-the-passage-of-mha-improvement-act_2022.pdf.

the Mental Health Parity and Addiction Equity Act: a critical civil rights law that protects most individuals in commercial insurance plans and Medicaid. Medicare's lack of parity perpetuates the stigma against older adults with substance use disorders and prevents them from getting the full scope and duration of services they need in a way that would be comparable to how Medicare covers medical conditions.[8] As the Departments of Labor, Treasury, and Health and Human Services continue to improve enforcement of the Parity Act in commercial insurance,[9] we urge Congress to ensure that Medicare beneficiaries do not continue to be left behind. The experience of these Departments in enforcing the Parity Act has illuminated that individual legislative and regulatory changes may be able to address the most glaring barriers to care, but they cannot address the unwritten implementation practices that limit access, which the Parity Act would. Improved access requires comprehensive non-discriminatory requirements to put the onus on Medicare Advantage and Prescription Drug plans to adopt and implement equitable standards and ensure the removal of discriminatory standards in Medicare Parts A and B. We recommend Congress apply the Parity Act to all parts of Medicare to ensure that older adults have non-discriminatory coverage of substance use disorder and mental health treatment.

2. *Remove Additional Barriers to Substance Use Disorder Treatment in Medicare Advantage Plans*

We have heard many stories from individuals in Medicare Advantage (MA) plans who face more significant barriers to substance use disorder treatment because of cost-sharing requirements, inadequate networks, and utilization management practices.[10] While Congress has removed the 20% cost-sharing requirement for beneficiaries with traditional fee-for-service Medicare for opioid treatment programs, many MA plans still require cost-sharing for this benefit, as well as many other substance use disorder treatment services. Many Medicare beneficiaries live on a fixed income; one-third report that it is difficult to afford health care costs and more than one in five beneficiaries report delaying or skipping health care they need because of the cost, with even higher rates among beneficiaries under age 65.[11] While we recommend Congress remove cost-sharing for all substance use disorder treatment services and medications in Medicare to help make care more affordable and accessible, and pass the MORE Savings Act sponsored by Chairman Casey, Congress can take a critical first step by requiring MA plans to, at a minimum, remove cost-sharing for opioid treatment program services to align with traditional Medicare.

We thank Congress for recognizing and working to address the woefully inadequate networks of substance use disorder and mental health providers in MA plans. Nearly two-thirds of MA plans' provider directories contain fewer than 25% of the psychiatrists in the plan's service area,

---

[8] Legal Action Center, "The Path to Parity: Applying the Parity Act to Medicare to Improve Access to Substance Use Disorder and Mental Health Care," (June 2022), https://www.lac.org/assets/files/Path-to-Parity-MAPP-2022.06.14.pdf.
[9] "Requirements Related to the Mental Health Parity and Addiction Equity Act," 88 Fed. Reg. 51552 (Aug. 3, 2023).
[10] Legal Action Center, "Out of Reach: How Gaps in Medicare Coverage of Substance Use Disorder Care Harm Beneficiaries" (June 2023), https://www.lac.org/assets/files/MAPP-Stories-2023.06.14-final-1-1.pdf.
[11] Gretchen Jacobson, Faith Leonard & Sara R. Collins, "Can Medicare Beneficiaries Afford Their Health Care? Findings From the Commonwealth Fund Health Care Affordability Survey," Commonwealth Fund (Oct. 2023), https://www.commonwealthfund.org/publications/2023/oct/can-medicare-beneficiaries-afford-their-health-care-2023-survey.

compared to 40% in Medicaid managed care and Affordable Care Act plans.[12] This high rate of "narrow" networks is much worse for mental health providers than those for medical conditions; only one-fifth of primary care and specialist MA networks were similarly narrow. Furthermore, in more than half of the counties for which data was available, there was not a single psychiatrist who participated in MA. Notably, the true rate of access to psychiatrists in MA plans is likely to be much worse because the data is based on provider directories, which often contain significant inaccuracies. The U.S. Senate Finance Committee conducted a secret shopper survey of MA plans this year, finding that more than 80% of mental health providers who were listed in the plans' directories were either unreachable, not accepting new patients, or not in fact in-network. Committee staff were able to schedule an appointment only 18% of the time.[13] This problem compounds for dual-eligible individuals, who also need to find a provider that accepts their Medicaid plan. These findings highlight the need for Congress and CMS to develop stronger network adequacy standards and protections in MA for substance use disorder and mental health providers.

Utilization management practices in MA plans also create additional barriers to substance use disorder treatment that force beneficiaries to delay or forego needed care. In 2022, approximately 98% of MA beneficiaries are enrolled in plans that require prior authorization for some substance use disorder and mental health services, and 26% were in plans that required referrals for some substance use disorder or mental health services.[14] A report from the Office of the Inspector General in 2022 found that 13% of MA plans' denied prior authorization requests actually met the Medicare coverage rules, meaning that those services would have been covered if the beneficiaries were enrolled in traditional Medicare.[15] Such denials prevent beneficiaries from getting the care they need, or lead to significant delays as beneficiaries are forced to appeal, which sadly only happens about 1% of the time even though the vast majority of these denials are overturned.[16] This is another instance where these utilization management practices can compound to further delay and restrict access to treatment for dual-eligible individuals, especially if they are also enrolled in Medicaid managed care plans. At a minimum, we recommend that Congress require MA plans to remove prior authorizations for medications for substance use disorders, consistent with the American Medical Association's model bill,[17] and

[12] Jane M. Zhu et al., "Psychiatrist Networks in Medicare Advantage Plans Are Substantially Narrower Than in Medicaid and ACA Markets," Health Affairs (July 2023), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2022.01547?utm_campaign=july+2023+issue&utm_medium=press&utm_source=mediaadvisory&utm_content=zhu&journalCode=hlthaff.

[13] Senate Committee on Finance, "Majority Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks" (May 3, 2023), https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf.

[14] Meredith Freed, Nolan Sroczynski & Tricia Neuman, "Mental Health and Substance Use Disorder Coverage in Medicare Advantage Plans," KFF (Apr. 28, 2023), https://www.kff.org/medicare/issue-brief/mental-health-and-substance-use-disorder-coverage-in-medicare-advantage-plans/.

[15] U.S. Dep't. Health & Human Services, Office of Inspector General, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care," (Apr. 2022), https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

[16] U.S. Dep't. Health & Human Services, Office of Inspector General, "Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials," (Sept. 2018), https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf.

[17] American Medical Association, "Model Bill: Ensuring Transparency in Prior Authorization Act," https://www.ama-assn.org/system/files/model-bill-ensuring-transparency-in-prior-authorization.pdf.

based on research demonstrating that the removal of this requirement is associated with increased access to care and improved health outcomes.[18]

B. Expand Capacity to Treat Beneficiaries with Substance Use Disorders and Reduce Costs

1. *Authorize Medicare Coverage of Community-Based Substance Use Disorder Treatment Facilities*

Medicare already covers Community Mental Health Centers, but its failure to cover the comparable settings of care for substance use disorder treatment (apart from opioid treatment programs) prevents older adults from getting the services they need in their communities. Mental health conditions and substance use disorders are not interchangeable, and many states prevent mental health practitioners from treating patients with substance use disorder diagnoses. Congress has authorized coverage of many of the services that are delivered in substance use disorder treatment facilities, but those benefits are not reaching beneficiaries because they cannot seek treatment at these clinics. Authorizing Medicare coverage of community-based substance use disorder treatment facilities would ensure that outpatient treatment, IOP, and PHP are truly available to people with substance use disorders because this is an essential setting for treatment. These facilities are certified and accredited by the states and they are already delivering treatment to Medicaid beneficiaries. The current lack of coverage also creates a significant barrier for dual-eligible individuals, who may be able to access care in these settings under Medicaid but face treatment delays when providers cannot get the necessary denial from Medicare to bill Medicaid. We recommend Congress authorize coverage of community-based substance use disorder treatment facilities in Medicare.

2. *Authorize Medicare Coverage of Residential Substance Use Disorder Treatment*

While Congress has closed many of the gaps in the substance use disorder continuum of care, one remaining glaring hole is Medicare's lack of coverage for residential substance use disorder treatment. Failing to cover this (and other) critically important level of care leads to more Medicare beneficiaries being hospitalized for their substance use disorder or comorbid medical conditions,[19] and greater costs to the Medicare program, the beneficiaries, the providers, and the states when these costs are merely shifted elsewhere. We recommend Congress authorize coverage of residential substance use disorder treatment in Medicare, consistent with the American Society of Addiction Medicine (ASAM) Criteria.

3. *Increase the Medicare Reimbursement Rates for Clinical Social Workers, Mental Health Counselors, and Marriage and Family Therapists*

---

[18] Tami L. Mark, William J. Parish & Gary A. Zarkin, "Association of Formulary Prior Authorization Policies with Buprenorphine-Naloxone Prescriptions and Hospital and Emergency Department Use Among Medicare Beneficiaries," JAMA Network Open (Apr. 20, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764598.

[19] William Parish & Tami Mark, "The Cost of Adding Substance Use Disorder Services and Professionals to Medicare," Legal Action Center (Aug. 2022), https://www.lac.org/assets/files/LAC_Medicare_Budget_Impact_Report_08_08_2022-submitted.pdf.

Clinical social workers, and as of January 2024, mental health counselors and marriage and family therapists, are reimbursed by Medicare at 75% of the PFS rate for psychologists. This represents a stark contrast to medical non-physician practitioners (e.g., occupational therapists, physical therapists, physician assistants, nurse practitioners, and clinical nurse specialists), who are reimbursed by Medicare at 85% of the PFS rate.[20] CMS has long recognized that the rates for substance use disorder and mental health services are already systemically undervalued,[21] and this substantial percentage decrease makes it unfeasible for many of these counselors to accept Medicare patients, leading to high Medicare opt-out rates among substance use disorder and mental health practitioners.[22] We recommend Congress increase the reimbursement rates for clinical social workers, mental health counselors, and marriage and family therapists to, at a minimum, align with the reimbursement rates for medical non-physician practitioners.

4. *Allow Opioid Treatment Programs to Deliver Services to Medicare Beneficiaries with Other Substance Use Disorders and Mental Health Conditions*

Opioid Treatment Programs play a pivotal role in curbing the addiction and overdose epidemic in the U.S., especially for Black and brown individuals who have greater access to these facilities but often lack sufficient access to office-based substance use disorder treatment.[23] Across the country, some of these programs are able to provide medications for alcohol use disorder as well as IOP for individuals with other substance use disorders or mental health conditions when they have Medicaid or private insurance. However, under Medicare statutes, opioid treatment programs can only deliver services to beneficiaries with opioid use disorder, even though alcohol use disorder remains the most common substance use disorder among this population.[24] To better meet the needs of Medicare beneficiaries, we recommend Congress authorize opioid treatment programs to deliver medications and services, including IOP, to Medicare beneficiaries with other substance use disorders.

5. *Amend the Medicare IOP and PHP Statutes to be More Inclusive of Substance Use Disorders*

As previously noted, Medicare's PHP benefit limits eligibility to beneficiaries who would otherwise need inpatient hospital treatment. However, according to the ASAM Criteria, there are a range of factors that must be considered together to determine whether a patient needs PHP, none of which require that the patient otherwise need hospital treatment. This statutory standard reinforces detrimental insurance practices in which individuals with substance use disorder and

---

[20] Meredith Freed, Juliette Cubanski & Tricia Neuman, "FAQs on Mental Health and Substance Use Disorder Coverage in Medicare (Jan. 18, 2023), https://www.kff.org/mental-health/issue-brief/faqs-on-mental-health-and-substance-use-disordercoverage-in-medicare/.

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

[22] Chris Larson, "43% of Medicare Opt-Outs Are Behavioral Health Providers," Behavioral Health Business (Apr. 26, 2022), https://bhbusiness.com/2022/04/26/43-of-medicare-opt-outs-are-behavioral-health-providers/.

[23] William C. Goedel et al., "Association of Racial/Ethnic Segregation with Treatment Capacity for Opioid Use Disorder in Counties in the United States," JAMA Network Open (Apr. 22, 2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2764663.

[24] *See* William J. Parish et al., *supra* note 3.

mental health conditions can receive treatment only when their needs are acute, which leads to patients cycling in and out of the emergency department and never getting their underlying chronic care needs met. We recommend Congress remove this requirement for PHP and clarify that IOP and PHP – as well as other levels of substance use disorder treatment – are reasonable and necessary for Medicare beneficiaries when consistent with the ASAM Criteria.

Another barrier to substance use disorder treatment is the requirement that a physician certify the need for IOP and PHP and develop the treatment plan, when in practice, non-physician practitioners like clinical social workers are often leading these treatment teams. CMS has permitted non-physician practitioners to certify the need for this treatment and develop the plan of care in opioid treatment programs, but it lacks the authority to do so for the other settings of care or for PHP. Allowing non-physician practitioners to perform these tasks is more consistent with how IOP and PHP are often delivered for individuals with substance use disorders, and we recommend Congress authorize comparable standards in the other settings for IOP and PHP.

C. Address Barriers to Care for Vulnerable Populations and Reduce Involvement with the Criminal Legal System

1. *Direct CMS to Remove the Overbroad Custody Exclusion in Medicare and Take Additional Steps to Strengthen Reentry*

Medicare imposes significant barriers to care for individuals who are under supervision of the criminal legal system but are living in the community. Current Medicare regulations prevent individuals who are not incarcerated or otherwise confined – such as those on parole, probation, bail, or supervised release – from receiving Medicare benefits, even though they are living in the community and not receiving correctional health care services. 42 C.F.R. § 411.4(b).[25] CMS eliminated similar exclusions in Medicaid and Federally-facilitated Marketplace plans in 2016,[26] and this Medicare regulation results in inconsistencies across the federal health care financing systems with devastating consequences for individuals ages 65 and older and people with disabilities who are reentering the community. Drug overdose death is the leading cause of death after release from prison, and studies suggest that recently incarcerated people are 10-40 times more likely to die from an overdose than the general public.[27] When older adults and people with

[25] Georgia Burke et al., "Reducing Barriers to Reentry for Older Adults Leaving Incarceration," Justice in Aging 7 (May 2022), https://justiceinaging.org/wp-content/uploads/2022/05/Reducing-Barriers-to-Reentry-for-Older-Adults-LeavingIncarceration.pdf.

[26] Centers for Medicare & Medicaid Services, "SHO # 16-007 Re: To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to Their Communities," Q2 and Q3 (April 28, 2016), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf; Centers for Medicare & Medicaid Services, "Incarceration and the Marketplace: Frequently Asked Questions" (May 3, 2016), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Incarceration-and-the-Marketplace-FAQs-05-03- 2016.pdf.

[27] *See* Daniel M. Hartung et al., "Fatal and Nonfatal Opioid Overdose Risk Following Release from Prison: A Retrospective Cohort Study Using Linked Administrative Data," Journal of Substance Use Addiction Treatment (Apr. 2023), https://www.sciencedirect.com/science/article/abs/pii/S2949875923000218?via%3Dihub; Elizabeth N. Waddell et al., "Reducing Overdose After Release from Incarceration (ROAR): Study Protocol for an Intervention to Reduce Risk of Fatal and Non-Fatal Opioid Overdose Among Women After Release from Prison," Health Justice (Dec. 2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7349469/; Shabbar I. Ranapurwala et al., "Opioid

disabilities are released from a correctional facility, it is critical that they have insurance to pay for care so that they can continue substance use disorder and any other treatment they received while incarcerated or initiate medically necessary treatment. We recommend Congress direct CMS to remove this overbroad custody exclusion in Medicare and align its definition with that in Medicaid and commercial insurance.

Additional actions Congress should take to strengthen reentry for older adults include:

- Passing the Reentry Act, which would promote continuous coverage and uninterrupted care access for older adults reentering the community from jails/prisons who are dually eligible for Medicaid and Medicare. The Legal Action Center appreciates Ranking Member Braun's leadership in sponsoring the Reentry Act;
- Promoting policies that support expanded use of compassionate release; and
- Reducing arrest/conviction record barriers to employment, housing and other key areas of life, including through advancement of federal Clean State policies.

2. *Authorize Medicare Coverage of Team-Based and Comprehensive Mobile Crisis Response Services*

We commend Congress for authorizing coverage of mobile crisis psychotherapy in the CAA, 2023 with an enhanced reimbursement rate and with direction to CMS to educate the community on how peers can help deliver crisis services. However, peers are not authorized to deliver psychotherapy services, and the mobile crisis teams in which they frequently work are not covered under Medicare, although they are covered in nearly three-quarters of state Medicaid programs.[28] Mobile crisis teams can be trained and equipped to respond to urgent substance use disorder concerns without dispatching law enforcement. Such encounters with law enforcement often lead to punitive responses and the criminalization of these conditions, rather than treatment, especially for Black and brown individuals. We recommend Congress authorize Medicare coverage of mobile crisis teams to help get Medicare beneficiaries the full range of crisis support they need and limit unnecessary involvement with the criminal legal system.

* * * * *

In conclusion, it is important for Congress to continue to expand Medicare's coverage for substance use disorder treatment and remove unnecessary barriers to care. In so doing, Congress can improve health outcomes and save lives, as well as reduce hospital costs and involvement with the criminal legal system. Thank you for the opportunity to speak with you today, and I look forward to answering your questions.

Overdose Mortality Among Former North Carolina Inmates: 2000-2015," Am. J. Public Health (Sept. 2018), https://ajph.aphapublications.org/doi/10.2105/AJPH.2018.304514.

[28] Heather Saunders, Madeline Guth & Nirmita Panchal, "Behavioral Health Crisis Response: Findings from a Survey of State Medicaid Programs," KFF (May 25, 2023), https://www.kff.org/mental-health/issue-brief/behavioral-health-crisis-response-findings-from-a-survey-of-state-medicaid-programs/.

LEGAL ACTION CENTER 810 First St, NE, Suite 200, Washington, DC 20002 T 202.544.5478 F 202.544.5712 nationalpolicy@lac.org www.lac.org