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Medicare Coverage of Medication Assisted Treatment (MAT) for Opioid Addiction

Medicare covers certain reasonable and necessary services provided by Medicare-enrolled health care practitioners for treating substance abuse disorders, such as alcoholism and opioid and other drug abuse. Medication Assisted Treatment (MAT) combines medication with counseling and behavioral therapies to provide comprehensive substance abuse treatment. Congress and the federal government have taken steps to increase the availability of MAT in response to a sharp increase in U.S. opioid overdoses and deaths in recent years. Effective January 1, 2020, the Support for Patients and Communities Act (SUPPORT; P.L. 115-271) added a Medicare benefit category for treating opioid use disorder, which includes comprehensive MAT services provided in the roughly 1,700 Substance Abuse Mental Health Services Administration (SAMHSA)-certified Opioid Treatment Programs (OTPs), also known as methadone clinics. OTP services include management, care coordination, psychotherapy, and counseling, as well as telehealth services and dispensing and administration of MAT drugs, including methadone. This brief provides background on MAT and Medicare coverage of MAT for opioid abuse treatment.

How Does MAT Work?

According to SAMHSA, MAT can provide a safe and controlled level of medication to help patients overcome or live with their opioid drug addiction. Research indicates that opioid use disorder treatment is most effective when drugs are used in combination with behavioral treatments and cognitive therapy (to challenge habitual individual behavior patterns).

The Food and Drug Administration (FDA) has approved three MAT medications for treating opioid dependence: methadone, buprenorphine, and naltrexone. Methadone and buprenorphine are opioid drugs with potential for dependence but also may be prescribed outside of MAT in different formulations for treating chronic pain. MAT drugs help to reduce or block an opioid drug's euphoric effects, relieve physiological cravings, and normalize body functions. Experts recommend that all three drugs be available for 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, when used for treating opioid abuse, may be administered as part of a hospital admission; otherwise, this medication may only be administered and dispensed by OTPs (see **Table 1**). OTPs may prescribe and dispense buprenorphine and naltrexone.

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 by prescribing buprenorphine, but not methadone, outside an OTP in other health care settings. In May 2016, FDA approved an implantable buprenorphine product that is effective for three months, and in November 2017, FDA approved an injectable formulation that is effective for one month. Implanted and injected buprenorphine formulations are administered in physician offices and other outpatient settings. Other buprenorphine formulations, such as pills, may be dispensed by retail pharmacies.

Naltrexone, a nonopioid drug, does not carry an addiction risk and is not regulated under the CSA. Naltrexone may be prescribed and dispensed in OTPs. It also may be prescribed by health care practitioners (without DATA 2000 waivers), who are licensed to prescribe drugs, and then dispensed by pharmacies.

Table 1. MAT Drug Practitioner Authority

MAT Medication	Practitioners Authorized to Prescribe/Dispense MAT Drugs		
	OTPs	DATA 2000 Waiver	Other Practitioners
Methadone	Yes	No	No
Buprenorphine	Yes	Yes	No
Naltrexone	Yes	Yes	Yes

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

Opioid Abuse in Medicare

The federal Medicare program provides health coverage for qualified individuals age 65 and older and permanently disabled individuals—about 63 million in 2020. Medicare benefits are provided through Part A, which covers inpatient hospital services; Part B, which covers physician services and other outpatient care; Part C, a managed care service delivery option that covers Parts A and B benefits (except hospice care); and Part D, a voluntary optional benefit that covers outpatient prescription drugs through private prescription drug plans.

Opioid overutilization is a significant issue in Medicare. A May 2020 Department of Health and Human Services Office of Inspector General (HHS OIG) report found that most of the 71,260 Part D enrollees at serious opioid abuse risk in 2017 received high opioid doses in 2018. Even though it appeared fewer of these Part D enrollees were doctor shopping or receiving extreme opioid doses, they had what the HHS OIG termed high opioid levels—a 120

morphine milligram equivalent (MME) average dose for at least three months. MME measures an individual's cumulative opioid use over a 24-hour period.

As required under the Comprehensive Addiction and Recovery Act of 2016 (CARA; P.L. 114-198), the Centers for Medicare & Medicaid Services (CMS) established a Part D opioid overutilization monitoring system (OMS) to help plans monitor opioid prescribing. CMS developed maximum dosage thresholds to identify potential opioid overutilization based on Centers for Disease Control and Prevention opioid prescribing guidelines. Under the OMS program, Part D plans are required to review and provide case management for at-risk enrollees (with some exclusions). MAT drugs are not counted in OMS dosage criteria. Beginning January 1, 2019, Part D plans could limit the number of prescribers and pharmacies used by enrollees at risk of overutilization of commonly abused drugs. Part D plans are required to impose these limits in 2022, but most plans (99%) had implemented these restrictions in 2019.

Medicare Coverage of MAT

Prior to January 1, 2020, Medicare did not include an OTP service benefit category, although some beneficiaries, with supplemental health coverage or who were enrolled in a Medicare Advantage plan, may have had coverage for some OTP services. Some Medicare beneficiaries also may have paid for OTP services themselves. To receive Medicare payment, OTPs must meet certain conditions, such as entering into a standard Medicare provider agreement, paying an application fee, and satisfying other OTP-specific requirements. OTPs could begin enrolling in Medicare in November 2019. As shown in **Table 2**, Medicare covers MAT services as a comprehensive benefit under Medicare Parts A, B, and C, as well as some MAT under Part D.

Table 2. Medicare MAT Coverage Summary

Medicare Part	Covered MAT Services
Part A	Inpatient services, including counseling, and MAT drugs administered during a covered stay in a Medicare-approved hospital or inpatient facility.
Part B	Outpatient counseling, physician services, and MAT drugs, including methadone administered or dispensed in OTPs and some buprenorphine formulations, such as injections and implants, administered by practitioners with DATA 2000 waivers.
Part C	Required Parts A and B covered services and Part D drugs if the Part C plan covers prescription drugs. For years beginning January 1, 2020, plans are required to cover OTP services.
Part D	MAT drugs prescribed by participating Medicare practitioners and dispensed by retail pharmacies, including some buprenorphine formulations, such as film or pills, and naltrexone. Methadone when prescribed for pain, depending on the plan. Methadone for MAT is not covered.

Source: CRS review of Medicare coverage and the SUPPORT Act.

Medicare Part A generally covers inpatient services, including substance abuse treatment in psychiatric or other qualified hospitals. (Medicare Part A covers up to 190 days of inpatient psychiatric hospital services during an enrollee's lifetime.) Part A covers FDA-approved drugs, including all MAT medications, when administered during a hospital admission. Medicare beneficiaries are responsible for applicable Part A deductibles and copayments.

Medicare Part B covers physician and professional services and may cover psychiatric services (partial hospitalization services) including therapy, drugs, and counseling. Beginning January 1, 2020, Part B covers MAT services provided in OTPs and may cover MAT—other than methadone treatment—in approved outpatient settings, such as community health centers or physician offices. Part B began covering insertion and removal of buprenorphine implants January 1, 2018. Medicare beneficiaries generally are responsible for Part B monthly premiums, an annual deductible ($198 in 2020), and coinsurance (20% of service cost). However, Medicare beneficiaries have no Part B cost-sharing or MAT services except the deductible.

Medicare Part C plans must cover MAT services available under Parts A and B and may offer outpatient prescription drug coverage under Medicare Part D. Part C plans must cover services provided by Medicare-participating OTPs because the services are covered under Part B.

Medicare Part D covers prescribed outpatient drugs that may be dispensed in retail pharmacies for medically accepted indications. Part D plans may cover methadone when prescribed for pain, but not methadone when used in MAT. Medicare Part D plans must cover other self-administered MAT drugs, either on their formularies (a list of covered drugs) or through a coverage exception requested by an enrollee. Under Medicare statute, each plan must cover at least two drugs in each class or category, except in six protected classes where plans must cover all drugs. CMS approves plan formularies and encourages plans to facilitate enrollment and limit restrictions for beneficiaries who require MAT. Beneficiaries are responsible for Part D monthly premiums and cost sharing. Cost sharing varies depending on the plan formulary and the beneficiary's required drugs.

Medicare MAT Coverage Demonstration

The President's FY2021 budget request provides for implementation of an Innovation Center model required by the SUPPORT Act. The model would test whether a care management fee and performance-based provider financial incentives would improve outcomes for beneficiaries being treated for opioid use disorder. The model could be expanded nationwide if it were found to be effective.

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