Public Policy Statement on Ensuring the Financial Sustainability of Addiction Treatment Services in the United States

Purpose

In 2023, almost 17% of Americans – 50 million people - met criteria for a substance use disorder (SUD) diagnosis.[1] Unfortunately, only 1 in 4 of those received any treatment, costing the US trillions of dollars in unmet medical burden and other societal costs.[2,3] While federal and state governments have taken crucial steps to address the addiction crisis in the United States (US), additional actions are urgently needed to secure the long-term financial sustainability of addiction treatment services across the full continuum of care as defined by nationally recognized standards. Otherwise, treatment programs for substance-related and behavioral addiction will be unable to meet today's demand for their services or survive arbitrary and nonevidence based regulatory and reimbursement environments. This public policy statement underscores the need for additional policy actions to ensure that the proper infrastructure is in place to support high-quality SUD and other addiction treatment services in the right place, and at the right time.

Background

While the number of Americans with SUD remains elevated, the number of addiction treatment facilities decreased between 2022 and 2023.[4] State and federal regulatory incentives remain misaligned; there is an underinvestment in addiction treatment by both public and private health insurers; non-profit hospitals are not meeting their legal and ethical obligations to address SUDs that are identified in their community health needs assessments; information on the quality of addiction treatment services is hard to find, as there is no established system to evaluate service quality, and there continues to be a critical shortage of addiction specialist physicians (ASPs) and other clinicians to meet the growing treatment demand.

Significant Gaps remain in both public and private third-party coverage for SUD

Health insurance coverage of addiction treatment programs at all levels of care is vital to addressing the chronic disease of addiction and reducing its health, economic and societal burdens. In the US, roughly 300 million Americans have some form of health insurance: employer-sponsored coverage (~50%), Medicare/Medicaid/TRICARE/CHAMPVA (~40%), and non-group health insurance plans (~6%), such as individual health plans on the Affordable Care Act (ACA)

Marketplaces.[5] Cuts to federal subsidies for ACA plans would drastically limit affordability for consumers and potentially increase the uninsured rate, according to experts.[6]

As of 2021, addiction treatment providers exhibited variability in the forms of payment accepted with roughly 42% accepting Medicare, 72% accepting Medicaid, and 75% accepting private insurance.[7] As a result, people covered by Medicare and their families may have the most difficulty finding treatment services which accept Medicare payments.

Medicare SUD coverage and parity gaps

Currently, Medicare covers SUD treatment, including behavioral therapies and medications, provided in outpatient, certain intensive outpatient, and inpatient hospital settings. Medicare also covers preventive services such as screening, brief intervention, and referral to treatment (SBIRT), as well as certain recovery support services.[8] However, Medicare does not cover SUD treatment provided in non-hospital residential settings. Additionally, inadequacy of federal parity protections applicable to Medicare allows for more coverage restrictions on SUD services compared to Medicare coverage for other medical and psychiatric services.

Medicaid cuts, low reimbursement, and the IMD Exclusion

Medicaid is the largest third-party payer of SUD treatment, even though its payment rates are on average about 70% of the Medicare rate.[9] These facts may partially explain why nearly 25% of SUD treatment facilities report non-participation, including an astounding 54% of SUD treatment facilities in California and 53% in Florida.[10] These are stark fiscal obstacles for addiction treatment programs across the levels of care that serve Medicaid patients. While some states have adopted measures to increase payment rates and invest in quality treatment, only about half of US states report any plans to increase Medicaid payment rates in 2025.[11] Substantial practice cost inflation following the COVID-19 pandemic, non-evidence-based regulations on the practice of addiction medicine, and the debut of telemedicine-only platforms that operate without typical practice costs or quality controls have exacerbated these issues. As a result, some addiction treatment programs are confronting harsh realities about their ability to remain open so they can meet the needs of patients in their communities.

Low Medicaid reimbursement rates established by states also fuel clinicians' and treatment programs' refusal to participate in-network with Medicaid. In turn, Medicaid managed care organizations (MCOs) can find it difficult to meet federal/state network adequacy requirements. Furthermore, Medicaid enrollees are more likely to have more severe SUD than patients with other types of health insurance, making them more susceptible to returning to substance use without access to treatment programs that accept Medicaid.

Furthermore, potential Medicaid policy changes, such as block grants, capitation and work requirements, may introduce additional uncertainty and risk for people who perceive a need for addiction treatment. States may make decisions that further limit eligibility, reduce services, and lower payment rates in ways that further erode the stability and fiscal solvency of addiction treatment services.[12] Reduction in services or eligibility would harm patients who rely on Medicaid for addiction treatment, decrease the quality of addiction treatment services, and severely limit innovation in Medicaid spending that has helped states to expand coverage and reduce the fiscal, economic, and health burden of addiction. Though innovations have been allowed through section 1115 waivers, historical policies such as the Medicaid Institutions for Mental Diseases (IMD)

exclusion continue to limit access to residential addiction treatment programs. The IMD exclusion prohibits the use of federal Medicaid financing for care provided to Medicaid beneficiaries aged 21-65 in mental health and residential SUD treatment facilities with more than 16 beds.

Weak parity enforcement and penalties

While there are federal parity protections in place for insurance coverage for addiction care (except for Medicare), implementation and enforcement of the Mental Health Parity and Addiction Equity Act remain challenging. In the current regulatory environment, different requirements apply to different insurers and parity enforcement is overseen by a cross-section of federal and state government agencies. Further, there is limited authority to assign significant civil monetary penalties for parity noncompliance.[13]

Non-profit Hospitals' Investment in SUD Treatment

Nearly 50% of SUD treatment facilities in the US are operated under a non-profit ownership model, with many having a direct affiliation with a non-profit hospital.[14] Notably, non-profit hospitals must demonstrate through the "community benefit standard" that they operate to promote the health of a class of persons broad enough to benefit the community.[15] These hospitals are required to assess community health needs through health needs assessments. Unfortunately, these assessments reveal that of the non-profit hospitals that have undertaken any strategy to address SUD, only 45% of those have undertaken strategies to invest in SUD treatment.[16] This data invites concern about the private sector's commitment to addressing addiction treatment needs, questions about the robustness of the community benefit standard, and leaves significant gaps in the care continuum.

Regulatory Controls Misaligned with Quality Care

Addiction treatment programs also operate under the oversight of non-evidence-based regulatory controls, which increase the cost of doing business, while failing to improve the overall quality of the treatment persons with addiction receive. Several states regulate buprenorphine for opioid use disorder (OUD) more stringently than other controlled medications in the same schedule, reducing the number of providers who can meet the regulatory burdens of providing care.[17] Federally, reporting requirements about so-called "suspicious orders" also limit patients' access to buprenorphine for OUD while increasing the time clinicians and staff must spend navigating issues at the pharmacy counter.[18] A tightly regulated federal system limits access to methadone for OUD treatment and excludes Medicare payment for SUDs other than OUD, leaving millions of people with suboptimal care in places where a federally-licensed opioid treatment program (OTP) exists and completely blocks access to this evidence-based modality of care where OTPs do not exist. At the same time, absent a determination that addiction treatment is a preventive service, which could make some addiction treatment services a covered benefit without beneficiary cost-sharing, many patients are subject to prohibitive cost-sharing requirements when they receive addiction treatment, especially in the case of high-deductible plans. Prohibitive cost-sharing increases the likelihood of treatment discontinuation. Finally, over-the-counter products approved by the FDA to address tobacco-related disorders and/or opioid overdose are not covered by health insurers (excluding discretionary funds exclusive to pharmacies), limiting utility for those unable to afford these treatments via self-pay and missing

an opportunity to address the health risks such as cancer posed by tobacco products, and increasing the risk of not having rescue medications available in an opioid overdose.

Recommendations

The American Society of Addiction Medicine recommends that:

1. **Federal and state governments undertake a comprehensive review of public/private health insurance SUD payment rates to:**
    - **ensure that public and private health insurers create appropriate reimbursement methodologies for addiction treatment programs that support evidence-based comprehensive care;**
    - **emphasize quality or performance measures for addiction treatment outcomes that are patient-centered and align with addiction as a chronic disease, remission as a treatment goal, and recovery as an ongoing process, and refrain from using as the desired or measured outcome, "completion of treatment" or cessation of professional services; and**
    - **promote reimbursement-based reward programs for adherence to nationally recognized, evidence-based, SUD-specific standards.**
2. **Congress fully extend federal mental health and addiction parity protections under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicare (including Advantage Plans), Medicaid (fee for service), CHAMPUS, CHAMPVA, and TRICARE.**
3. **In lieu of attempts to fundamentally alter federal Medicaid financing, impose work requirements, or halt continuance of ACA subsidies, Congress takes steps to:**
    - **continue to ensure that there are no duplicative payments or "fraud, waste, and abuse" found in Medicaid, as those terms are commonly understood;[19]**
    - **condition federal Medicaid payments to addiction treatment programs on adherence to nationally recognized, evidence-based, SUD-specific standards developed by a nonprofit medical association generally recognized for its expertise in addiction treatment; and**
    - **ensure that private insurance, Medicaid, and Medicare cover and adequately reimburse for addiction treatment services.**
4. **Congress act to allow Medicare reimbursement of treatment for all cooccurring cases of MH and substance-related disorder (as opposed to solely MH and opioid use disorder) and comorbid medical and psychiatric care provided in OTPs and in state-licensed SUD treatment facilities that meet nationally recognized, evidence-based, SUD-specific standards.**
5. **States act to replicate the Medicare OTP and office-based SUD care management[20] benefits in their Medicaid programs as a means to support expanded access to treatment.**
6. **Congress act to incentivize access to quality SUD treatment by increasing Medicaid payment rates for SUD services to 100 percent of the Medicare rate for the same service for healthcare professionals who specialize in SUD treatment.**
7. **Payers cover all FDA-approved/cleared pharmacotherapies and devices for substance use disorders including tobacco use disorders, in clinically appropriate doses and**

durations, without prior authorization, and provide benefit coverage for over-the-counter SUD and harm reduction products.

8. **Payers eliminate cost sharing policies for FDA-approved/cleared pharmacotherapies and devices.**
9. **Congress or the Internal Revenue Service reform the community benefit standards to incentivize non-profit hospitals to invest no less than a certain percentage of annual revenues in SUD treatment.**
10. **Congress takes targeted actions to provide financial incentives to expand the number of addiction specialist physicians and other healthcare professionals specializing in treating addiction.**

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[19] 5 Key Facts about Medicaid Program Integrity | KFF. KFF. Published March 17, 2025. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-program-integrity-fraud-waste-abuse-and-improper-payments/
[20] Medicare pays for a monthly bundle of services for the treatment of SUD, including: overall management, care coordination, individual and group psychotherapy, and substance use counseling. More information can be found here.