Medicare Minute Teaching Materials — February 2021
Medicare Coverage of Behavioral Health Services

1. What is behavioral health care?

Behavioral health care includes services and programs intended to help diagnose and treat mental health illnesses and addiction-related issues. According to the National Alliance on Mental Illness (NAMI), "a mental illness is a condition that affects a person's thinking, feeling, or mood." Examples of mental health illnesses include depression, anxiety, and schizophrenia. Substance use disorders and addiction do not fall under this definition of mental health illness, but they are considered behavioral health conditions. Examples of addiction disorders include opioid use disorder (OUD) and alcoholism. It is important to note that behavioral health conditions are typically not the result of any single event or circumstance. Rather, they tend to be complicated conditions involving an interplay of biological and environmental factors.

2. What costs should I expect with inpatient behavioral health care?

Medicare Part A covers inpatient mental health and addiction recovery services that you receive in either a psychiatric hospital (a hospital or distinct unit in a hospital that only treats mental health patients) or a general hospital or inpatient rehabilitation facility. Your doctor should determine which hospital setting you need. If you receive care in a psychiatric hospital, Medicare covers up to 190 days of inpatient care in your lifetime. If you have used your lifetime days but need additional mental health care, Medicare may cover additional inpatient care at a general hospital.

You will have the same out-of-pocket costs with Original Medicare whether you receive inpatient care in a general or psychiatric hospital:

- The Part A deductible: Before Medicare covers the cost of inpatient care, you have to meet the deductible for the benefit period. In 2021, the deductible is $1,484.
    - Benefit periods measure your use of inpatient hospital and skilled nursing facility (SNF) services. A benefit period begins the day you are admitted to a hospital as an inpatient, or to a SNF, and ends the day you have been out of the hospital or SNF for 60 days in a row.
- Days 1-60 of a benefit period: After you meet the deductible, Medicare pays in full for the first 60 days of your care.
- Days 61-90 of a benefit period: Medicare pays part of the cost, and you are responsible for a daily coinsurance charge. In 2021, the coinsurance is $371 per day.
- Lifetime reserve days: For up to 60 lifetime reserve days, Medicare pays part of the cost, and you are responsible for a daily coinsurance charge. The coinsurance in 2021 is $742 per day. Note that if you enter a psychiatric hospital within 60 days of being an inpatient at a different hospital, you are in the same benefit period and do not have to pay the Part A deductible again.

If you have a Medicare Advantage Plan, your plan must cover the same mental health and addiction recovery services as Original Medicare but may impose different costs and restrictions. If you need information about the costs and coverage requirements, or if you are experiencing problems, you should contact your Medicare Advantage Plan.

3. How does Medicare cover outpatient behavioral health care services?

Medicare Part B covers outpatient behavioral health care, including the following services when medically necessary and delivered by a Medicare-enrolled provider:

- Individual and group therapy with a doctor or other licensed related health professional
- Substance use disorder treatment
- Tests to make sure you are getting the right care
- Occupational therapy if the main purpose is to help with treatment
- Activity therapies such as art, dance, or music therapy if the main purpose is to help with your treatment
- Training and education (such as training on how to inject a needed medication or education about your condition)
- Family counseling if the main purpose is to help with your treatment
- Laboratory tests
- Prescription drugs that you cannot self-administer, such as injections that a doctor must give you
- An annual depression screening that you receive in a primary care setting. You should speak to your doctor or primary care provider for more information.
    - The depression screening is considered a preventive service, and Medicare covers depression screenings at 100% of the Medicare-approved amount.
- An annual alcohol misuse screening and (if after the screening your doctor determines you are misusing alcohol) four brief counseling sessions per year that you receive in a primary care setting.
    - The alcohol misuse screening and four brief counseling sessions are considered preventive services, and Medicare coverage is at 100% of the Medicare-approved amount, meaning there is no cost sharing if you see a provider who takes assignment.

Medicare Part B covers care you receive through an outpatient hospital program, at a doctor's or therapist's office, or at a clinic. You may receive services from the following types of providers:

- General practitioners
- Nurse practitioners
- Physician's assistants
- Psychiatrists
- Clinical psychologists
- Clinical social workers
- Clinical nurse specialists

You should make sure that any provider you see accepts assignment, meaning that they accept Medicare's approved amount as full payment for a service, to avoid paying more. If you see a non-medical doctor (such as a clinical psychologist or clinical social worker), it is especially important to make sure that your provider accepts Medicare payments. Medicare will only pay for the services of non-medical providers if they are signed up to accept Medicare payments.

Note: Psychiatrists are more likely than any other type of provider to opt out of Medicare. An opt-out provider does not accept Medicare payment and has signed an agreement to be excluded from the Medicare program. You should be sure to ask any provider if they take your Medicare insurance before you begin receiving

services. If you see an opt-out provider, the provider must have you sign a private contract. The contract states that your doctor does not accept Medicare payment and that you must pay the full cost of the service. Medicare will not reimburse you if you see an opt-out provider. If an opt-out provider does not present you with a private contract, you are not responsible for the cost of the services.

4. How does Medicare cover partial hospitalization for mental health treatment?

Medicare Part B covers partial hospitalization for mental health treatment. Partial hospitalization programs offer outpatient care in a hospital setting on a part-time basis, which can mean only during the day, only at night, or only during weekends. Partial hospitalization programs provide care that is more intensive than other forms of outpatient mental health care, but less intensive than inpatient care. In such a program, you will follow a plan of care tailored to your needs. Services may include the following:

- Individual or group therapy
- Occupational therapy
- Activity therapies, such as art, dance, or music therapy, when they are used to help you meet the goals of your plan of care
- Prescription drugs that you cannot administer yourself
- Training and education closely related to your plan of care
- Family counseling that primarily supports your treatment (not if it primarily promotes the general wellbeing of the family)
- Services needed to diagnose your condition and evaluate your care

Partial hospitalization programs may be offered by hospital outpatient departments and by community mental health centers. Medicare covers your partial hospitalization care if both of the following apply:

- A doctor certifies that:
    - You would otherwise need inpatient treatment, or you have recently been discharged from inpatient care and need partial hospitalization to avoid a relapse in your condition
    - And, less intensive treatment options (such as outpatient therapy) would not be enough to help you avoid hospitalization.
- You receive care from a Medicare-certified program

5. Which addiction recovery services does Medicare cover?

Medicare covers treatment for alcoholism and substance use disorders in both inpatient and outpatient settings if:

- Your provider states that the services are medically necessary
- You receive services from a Medicare-approved provider or facility
- And, your provider sets up your plan of care.

Covered services include but are not limited to:

- Patient education regarding diagnosis and treatment
- Psychotherapy
- Post-hospitalization follow-up
- Opioid treatment program (OTP) services (see question 7)
    - FDA-approved opioid treatment medications (methadone, buprenorphine, naltrexone)

        - Dispensing and administering drug, if applicable
    - Substance use counseling
    - Individual and group therapy
    - Toxicology testing
    - Intake activities and periodic assessments
- Prescription drugs administered during a hospital stay or injected at a doctor's office
    - Methadone may be covered in inpatient hospital settings
- Outpatient prescription drugs covered by Part D
    - Part D plans must cover medically necessary drugs to treat substance use disorders
        - Part D plans cannot cover outpatient methadone or similarly administered medications to treat substance use disorders, but they can cover methadone for other conditions, such as pain. (Note: OTPs can provide methadone for substance use disorder treatment.)
- Structured Assessment and Brief Intervention (SBIRT) services provided in a doctor's office or outpatient hospital. SBIRT is covered by Medicare when an individual shows signs of substance use disorder or dependency. SBIRT treatment involves:
    - Screening: Assessment to determine the severity of the substance use disorder and identify the appropriate level of treatment.
    - Brief intervention: Engagement to provide advice, increase awareness, and motivate individual to make behavioral changes.
    - Referral to treatment: If individual is identified as having additional treatment needs, provides them with more treatment and access to specialty care.

Inpatient care
Part A covers your care if you are hospitalized and need treatment for a substance use disorder. Cost-sharing rules for an inpatient hospital stay (see number 2) should apply.

Note: If you are receiving care at an inpatient psychiatric hospital, keep in mind that Medicare only covers a total of 190 lifetime days.

Outpatient care
Part B covers outpatient care for a substance use disorder that you receive from a clinic, hospital outpatient department, or opioid treatment program. Note that some substance use disorder treatment can also be provided using technology services, sometimes called telehealth.
Original Medicare covers mental health services, including treatment for alcoholism and substance use disorders, at 80% of the Medicare-approved amount. As long as you receive the service from a participating provider or one who takes assignment, you will owe a 20% coinsurance after you meet your Part B deductible. If you are enrolled in a Medicare Advantage Plan, you should contact your plan for cost and coverage information about treatment for a substance use disorder. Your plan's deductibles and copayments/coinsurance may apply.

6. Does Medicare cover drugs needed for mental health care?
To get Medicare prescription drug coverage, you must be enrolled in a Medicare Part D prescription drug plan. Part D is offered through private companies either as a stand-alone plan for those enrolled in Original Medicare,

or as a set of benefits included with a Medicare Advantage Plan. Part D plans vary in cost and in the specific drugs they cover.

Each plan has a list of covered drugs, called a formulary. You should check before joining a Part D plan to ensure that any drugs you need are on that plan's formulary. If your drug is not on formulary, you may have to request an exception, pay out of pocket, or file an appeal to ask your plan to cover the drug. While Part D plans are not required to cover all drugs, they are required to cover all antidepressant, anticonvulsant, and antipsychotic medications (with limited exceptions).

Some medications used to treat substance use do not meet certain requirements for coverage under Medicare Part D. These medications can be covered by Part A during an inpatient stay or by Part B as part of medication-assisted treatment (MAT) at an opioid treatment program (OTP).

7. How does Medicare cover opioid treatments programs?
Medicare Part B covers opioid use disorder (OUD) treatment received at opioid treatment programs. Opioid treatment programs (OTPs), which are also known as methadone clinics, are certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide methadone as part of medication-assisted treatment. OTPs are the only place where an individual can receive methadone to treat opioid use disorder.

In order to receive Medicare coverage for OTP services, the OTP must:

- Be certified by SAMHSA
- Enroll in the Medicare program

Once an OTP is enrolled in Medicare, it can bill Medicare for the services provided to you. Therefore, if you want to get Medicare-covered OTP services you should contact the OTP to make sure it accepts Medicare. If the OTP is not enrolled in Medicare, you are responsible for the cost of the care.

If you have both Medicare and Medicaid and were previously receiving Medicaid-covered OTP services, Medicaid should continue to pay primary for treatment until the OTP is enrolled in Medicare. At this time, once you meet your deductible, you will not owe any cost-sharing (coinsurance or copayment) for OTP.

8. What is a drug management program?
A drug management program is a tool that Part D plans can use to limit at-risk beneficiaries' access to certain drugs. Plans use clinical guidelines to identify beneficiaries who are at risk for misuse or abuse of frequently abused drugs, such as opioids.

At-risk beneficiaries may be required to use one provider and/or one pharmacy to get flagged medications. This is known as pharmacy/provider lock-in. If an at-risk beneficiary has Extra Help, an assistance program that helps with drug costs, they cannot use the Extra Help Special Enrollment Period (SEP) to make changes to their coverage. Normally, the Extra Help SEP allows most beneficiaries with Extra Help to change their coverage up to once per quarter for the first three quarters of the year.

If a beneficiary is found to be at risk, their plan must send two notices.

- The **first notice** declares the beneficiary potentially at risk. It includes:
  - The plan's proposed coverage limitations (such as pharmacy lock-in)
  - Information on any limitation on the availability of the Extra Help SEP, if relevant to the beneficiary
  - Timeframe for the plan's decision. The beneficiary has 30 days to submit relevant information, for example information about why they may be exempt from the lock-in, to the plan. They also may submit pharmacy/prescriber preferences, in the case of a proposed lock-in
- The **second notice** declares the beneficiary at risk and gives them the option to select provider and pharmacy preferences, as well as to appeal for redetermination.

9. What are safety reviews?

A safety review is a check that a plan and/or pharmacist may do if you fill a prescription for certain medications, such as an opioid pain medication.

The safety review may be for:

- Potentially unsafe opioid amounts
- Opioid use with benzodiazepines
- New opioid use (in which case, you may be limited to a seven-day supply or less)

If your pharmacist cannot fill the prescription because it is deemed unsafe, the pharmacist should give you a notice about how to request a coverage determination from the plan. Requesting a coverage determination is the first step you must take before beginning the appeal process. If the plan denies coverage, you can begin an appeal to ask your plan to cover the drug. If possible, you should contact your doctor for support with an appeal.

10. What is outpatient mental health care fraud?

Outpatient mental health care fraud occurs when Medicare is billed for mental health care services that you did not receive. You can report fraud or errors to your Senior Medicare Patrol, or SMP. Contact information for your SMP is on the last page of this document. Report potential outpatient mental health care fraud, errors, or abuse if:

- You spend the day at a facility playing games or watching TV and Medicare is then billed for group psychotherapy.
- You and other beneficiaries are picked up by a bus or a van, taken out for a meal, and then Medicare is billed for a psychiatric evaluation.
- You see other incorrect charges on your Medicare Summary Notice or Explanations of Benefits, such as mental health services in excess of what you received or that you never received.

For more information about outpatient mental health care fraud, view the SMP's Tips for Protecting Yourself and Medicare on the topic.

11. Where can I begin if I need mental health care or addiction recovery services?

You can start by contacting your doctor to ask about what services are available, and to ask if your doctor can recommend providers. If you have Original Medicare, you can use the Provider Compare tool on www.medicare.gov to find mental health care providers who accept Medicare payment. If you have a Medicare

Advantage Plan, you can contact your plan to find mental health care providers who are in network and to learn about any costs or restrictions associated with getting care.

You can also contact your **State Health Insurance Assistance Program (SHIP)** for help finding local resources and guidance on Medicare's covered behavioral health care services. SHIP counselors provide unbiased Medicare counseling and assistance. Contact information for your SHIP is on the last page of this document.

If you believe you may have experienced mental health care fraud, errors, or abuse, you can contact the **Senior Medicare Patrol (SMP)**. SMPs empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse. Contact information for your SMP is on the last page of this document.

If you have trouble finding a behavioral health provider, there are a number of national resources that can provide assistance:

- National Alliance on Mental Illness (NAMI)
  - Call 800-950-NAMI (6264)
  - Email info@nami.org
- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - Call 800-662-HELP (4357)
  - Visit https://findtreatment.samhsa.gov
- National Suicide Prevention Lifeline
  - Call 800-273-8255

SHIP Case Study
Penny wants to begin individual therapy with a psychiatrist or psychologist, but she is not sure where to begin and how to make sure Medicare will cover her care.

What should Penny do?

- Penny should first find psychiatrists and psychologists in her area whose services would be covered by Medicare.
  - If Penny has Original Medicare, she can use the Provider Compare tool on www.medicare.gov or call 1-800-MEDICARE to find providers near her who accept Medicare.
  - If Penny has a Medicare Advantage Plan, she can contact her plan to find mental health care providers who are in network and to learn about any costs or restrictions associated with getting care.
  - Penny can also ask if her doctor can recommend any providers or services.
  - If she has troubles finding a behavioral health provider, Penny can reach out to national resources like NAMI or SAMHSA.
- Once she has found a behavioral health care provider, Penny should confirm that Medicare will cover her therapy sessions before she begins receiving services.

- If Penny has chosen to see a clinical psychologist (or any other non-medical provider like a clinical social worker), she should check with the provider that they are Medicare-certified and accept Medicare payments.
- If Penny has chosen to see a psychiatrist, she should check that they accept Medicare payments. Psychiatrists commonly opt-out of Medicare, so Penny should make sure she is not being asked to sign a waiver by an opt-out provider, which would require her to pay out of pocket and would prohibit Medicare from reimbursing her for the cost of services she receives.

SMP Case Study

Lucinda has monthly hour-long individual therapy sessions with a psychiatrist who accepts Medicare insurance. When she receives her Medicare Summary Notice (MSN) in the mail, she sees that her Medicare coverage was billed for two of these therapy sessions per month, each lasting an hour and a half. Her Medicare was billed for a total of three hours per month, rather than one. Lucinda is certain that she has never visited her psychiatrist more than once per month or had sessions lasting more than an hour.

What should Lucinda do?

- Lucinda can contact her local Senior Medicare Patrol (SMP) for advice.
  - If she does not know how to contact the SMP, she can call 877-808-2468 or visit www.smpresource.org.
- The SMP may instruct Lucinda to call her psychiatrist or, if applicable, the psychiatrist's billing department to let them know about the error. She can ask them to correct the error(s) and resubmit the claims to Medicare correctly.
- If the psychiatrist or billing department is unresponsive or refuses to correct the error(s), the SMP can help Lucinda report the potential fraud to the correct authorities.
- The SMP team member should encourage Lucinda to continue carefully checking her MSNs and bills to ensure that she can catch errors like this one in the future as well.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free:	**SMP toll-free:**
SHIP email:	**SMP email:**
SHIP website:	**SMP website:**
To find a SHIP in another state: Call 877-839-2675 or visit www.shiptacenter.org.	**To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

This document was supported, in part, by grant numbers 90SATC0002 and 90MPRC0002 from the Administration for Community Living (ACL), Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official ACL policy.