Helping Clients Access Medicare-Covered Behavioral Health Care Services

People with Medicare who need behavioral health care may face a unique set of barriers in accessing covered care. This fact sheet is designed in partnership with Medicare Rights Center to help New York advocates, professionals, and peer specialists assist their clients by advising them on troubleshooting strategies and connecting them with resources.

If you have questions, email the Medicare Rights Center or Community Service Society (CSS) at:

- champta@medicarerights.org
- champta@cssny.org

You can also call the Community Health Access to Addiction and Mental Healthcare Project (CHAMP) helpline: 888-614-5400.

What does Medicare cover?

Medicare Part A covers inpatient behavioral health services received in a psychiatric hospital (hospital or distinct unit in hospital that only treats mental health patients) or a general hospital.

Medicare Part B covers outpatient mental health care, including:

- Individual and group therapy
- Partial hospitalization programs
- Substance use disorder treatment
- Tests to make sure beneficiary is getting the right care
- Occupational therapy
- Activity therapies, such as art, dance, and music therapy
- Training and education (such as how to inject needed medication)
- Family counseling
- Laboratory tests
- Prescription drugs administered by doctor
- Annual depression screening in primary care setting

Medicare Part B also covers outpatient substance use disorder care at Medicare-certified clinics, opioid treatment programs, or hospital outpatient department. Some substance use disorder treatment can also be provided using telehealth.

Covered services include, but are not limited to:

- Patient education regarding diagnosis and treatment
- Early intervention and referral to treatment (also known as Screening, Brief Intervention, & Referral to Treatment (SBIRT))
- Psychotherapy
- Detoxification
- Post-hospitalization follow-up
- Medication-assisted treatment (MAT)

Medicare also covers substance use disorder treatment in inpatient and outpatient settings if:

- A beneficiary's provider states that services are medically necessary
- They receive services from a Medicare-approved provider or facility
- And their provider sets up a plan of care

Medicare Part D covers prescription drugs. Each Part D plan has a formulary, which is a list of covered drugs. All Part D plans must cover substantially all drugs in certain classes, including some drug classes used to treat mental health conditions. These classes include antidepressants and antipsychotics.

Note that medications used to treat substance use disorder can be covered under Part A during an inpatient hospital stay or by Part B as part of outpatient medication-assisted treatment. Part D plans cannot cover outpatient methadone or similarly administered medications to treat substance use disorder (these are covered by Part A or B), but they can cover methadone for other conditions, such as pain.

Access barriers

Provider status

For behavioral health services to be covered, beneficiaries must see providers who have signed up to be able to bill Medicare. And while many providers have signed up to be able to bill Medicare for services they provide to beneficiaries, some providers have not. These providers are known as opt-out providers, and they have signed an agreement not to be part of the Medicare program at all. They cannot bill Medicare for services they provide to people with Medicare. Beneficiaries enter into a private agreement with opt-out providers about how much they will pay for services.

Some behavioral health providers do not sign an agreement or do not correctly opt out of Medicare. These providers may advise beneficiaries to pay for services out of pocket and submit their bill and claim information to Medicare. However, if a provider has not signed up with Medicare, the beneficiary should not be reimbursed.

A provider's status can be critical for a beneficiary's access to mental health care and substance use disorder services. However, mental health care providers are more likely than other types of providers to opt out of Medicare. As substance use disorders and mental health conditions are often co-occurring, barriers to mental health care can also impact substance use disorder treatment.

Excluded providers and services

Some providers are not eligible to be Medicare providers at all, meaning Medicare will not cover services a beneficiary receives from them. These providers include Certified Peer Specialists, Credentialed Alcoholism and Substance Abuse Counselors, and Licensed Professional Counselors. (Note that Licensed Counselors and Licensed Marriage and Family Therapists have also been excluded, but some will be allowed to bill Medicare Part B directly for their services starting January 1, 2024.)

These exclusions limit the types of providers people with Medicare have access to. In some cases, providers excluded from Medicare may be the only mental health care professionals available where a beneficiary lives. Beneficiaries are responsible for the entire cost of these services.

Excluded services also present an issue. Medicare does not cover residential treatment for substance use disorder or mental health treatment, but many

beneficiaries need or want to receive care from residential programs. If they do, they are responsible for the entire cost of this care.

Networks and utilization management tools

There also are access issues specifically related to Medicare Advantage and Part D coverage.

Medicare Advantage Plans may require beneficiaries to see an in-network provider for their care to be covered or require the beneficiary to pay a higher copay or coinsurance if they go out of network. However, plan provider networks are often inadequate and may not have enough substance use disorder or mental health treatment providers and facilities in-network. Furthermore, a plan's provider directory may be outdated. Currently, Medicare Advantage Plans only have network adequacy requirements for psychiatry and inpatient psychiatric facilities. All other behavioral health providers and settings are not included. Starting January 1, 2024, plans will be required to add clinical psychologists and licensed clinical social workers as specialty provider types with their own network adequacy standards. Plan networks will also be required to meet standards for wait times for behavioral health care services.

Medicare Advantage Plans may also use utilization management tools, which are methods that insurance companies use to limit costs and evaluate the services an enrollee receives. One example of a utilization management tool is prior authorization, which requires a beneficiary to get permission from their plan before receiving a service. Starting January 1, 2024, emergency behavioral health services cannot be subject to prior authorization. If a beneficiary's plan requires prior authorization for these services after January 1, 2024, the beneficiary should file a complaint against their plan with 1-800-MEDICARE (1-800-633-4227).

Part D plans use utilization management tools, too. For example, plans may use prior authorization, quantity limits (a limit on the amount of a medication a beneficiary can get), or step therapy (a beneficiary has to try a cheaper medication before the plan covers a more expensive one). Part D plans may also perform safety reviews on a medication, which can result in safety edits that require the beneficiary to get permission from their pharmacist, plan, or provider before the medication is dispensed and covered.

For enrollees in both Medicare Advantage and Part D plans, these utilization management tools and other restrictions hinder access to care by incorporating additional steps to get coverage.

Drug management programs

Part D plans can implement drug management programs to limit opioid access for at-risk beneficiaries. This is when plans use clinical guidelines to identify beneficiaries at risk for misusing medications, such as opioids. If a beneficiary's plan flags them as being at-risk, they may be required to use one provider and one pharmacy to get flagged medications (known as pharmacy or provider lock-in) and are limited in their ability to use Special Enrollment Periods to make coverage changes.

Tips for accessing care

While some access barriers are the result of larger structural problems, there are some steps that advocates can take to help their clients navigate the existing system.

Support clients' health insurance literacy

Health insurance can be difficult to navigate, and an unfamiliarity with how insurance works may lead to a beneficiary receiving an uncovered service and being responsible for unexpected costs.

Help clients understand the basics of their health insurance, such as what deductibles, copayments, and coinsurance charges are, and the importance of seeing providers who accept their insurance.

When possible, an individual should find out the following information before getting a service:

- Is this service covered by their Original Medicare or their Medicare Advantage Plan?
- If they have a Medicare Advantage Plan, is the provider or facility in-network?
- How much should they expect to pay for this service? Will they owe a deductible, copayment, and/or coinsurance?

Help clients navigate Medicare coordination of benefits

You should also confirm whether the client has insurance other than Medicare. Sometimes a secondary insurance may pay for costs after Medicare has paid,

Encourage clients to show all of their health insurance cards to their providers so that all of their insurance is billed.

A client's other insurance can sometimes cover services that Medicare does not. For example, if a client has Medicare and Medicaid, Medicaid may cover services that are excluded from Medicare, such as residential treatment. Some providers may want the beneficiary to get a Medicare denial first, but this is not required. If this happens, advise the beneficiary to let their provider know that the service is excluded from Medicare.

Use resources to find care and confirm provider status

If a client has Original Medicare, look up providers and facilities on www.medicare.gov/care-compare. Look for providers who are designated as ones who charge the Medicare-approved amount. Beneficiaries have the lowest out-of-pocket costs when they see these providers. They will be marked like this in the provider search tool:

Charges the Medicare-approved amount (so you pay less out-of-pocket)

If a client has a Medicare Advantage or Part D plan, contact the plan directly to find in-network providers and pharmacies and learn about covered services and prescriptions. Many plans have online provider directories, too.

If a client needs help finding providers or facilities, you can also use:

- Substance Abuse and Mental Health Services Administration (SAMHSA) resources:
  - www.samhsa.gov/find-help/national-helpline
  - www.findtreatment.gov
- New York State Office of Addiction Services and Supports (OASAS) https://findaddictiontreatment.ny.gov/
- New York State Office of Mental Health: www.my.omh.ny.gov/bi/pd/saw.dll?PortalPages

Help clients appeal medication denials and safety edits

Sometimes a client may not be able to access a needed medication, such as an opioid, because of a safety edit. Safety edits are intended to promote safe and effective use of medications. The safety edit occurs at the point of sale (POS),

where and when the beneficiary picks up and pays for their prescription. For opioids, the POS is almost always at the pharmacy. There are two types of safety edits:

- Soft edit: Pharmacist is alerted to the safety edit but may override the edit using a code in order to fill the prescription.
- Hard edit: Prescription may not be filled by the pharmacist without a prior authorization or a coverage determination from the plan

If a beneficiary's medication has a soft edit, you can help them access their medication by informing them that their pharmacist should be able to get rid of the safety edit at the pharmacy.

If a beneficiary's prescription cannot be filled because of a hard edit, they can request a coverage determination. This process asks the plan to reconsider its decision not to cover the prescription. The beneficiary's provider should provide evidence to the plan that the prescription is medically necessary. The pharmacist may attest to medical necessity and require an expedited determination from the plan. If the plan makes a determination in favor of the beneficiary, approval should be valid for the remainder of the plan year.

Help clients access medication-assisted treatment (MAT)

Part B covers MAT administered by approved Medicare facilities and providers, including opioid treatment programs. However, some providers may try to bill a beneficiary's Part D prescription drug plan for methadone or other medications used for MAT as part of an opioid treatment program. This can result in coverage denials or other issues. You can help a beneficiary resolve such issues by educating their provider on how to properly bill Part B or the health coverage portion of a beneficiary's Medicare Advantage Plan for opioid treatment program services.

Part B also covers MAT for medications that a beneficiary gets administered in a doctor's office. If a pharmacy mistakenly tries to bill a beneficiary's Part D plan for the medication, it may be denied. You or the beneficiary should inform the pharmacist or a beneficiary's provider that they need to bill Part B or the health coverage portion of the Medicare Advantage Plan, instead.

Use informal support systems

Learn if a client has a friend, family member, peer, or other person in their life who can help them navigate their care. For example, it may be helpful for a beneficiary to bring someone with them to doctors' appointments or have someone to help them keep medical paperwork organized.

Clearly communicate with a beneficiary's doctor

Sometimes a provider may be unfamiliar with Medicare's coverage rules, which can prevent a beneficiary from getting covered care. As an advocate, you can help by sharing provider educational resources from Medicare. These resources are usually from the Medicare Learning Network (MLN), and they explain coverage and billing information.

- List of MLN publications

If a provider has questions about coverage criteria or how to bill for a service, direct them to their Medicare Administrative Contractor (MAC) or the beneficiary's Medicare Advantage or Part D plan.

- The MAC for New York is called National Government Services (NGS) Medicare. They can be reached at 888-855-4356.
- Medicare Advantage and Part D plans often have provider-specific lines that a provider can contact.