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Medicare COVERAGE OF MENTAL HEALTH SERVICES

In recognition of Older Americans' Mental Health Week (May 24-30, 2009), this Weekly Alert reviews the mental health services that are available under the Medicare Program.^[1] Advocates seek improved access to mental health services, an expansion in the scope of services covered, and an increase in the types of providers whose services are covered. For example, transportation to obtain mental health care services is not covered, nor is there Medicare coverage for beneficiary testing and training for skills for various occupations.

While work remains to be done, we can celebrate the advances in Medicare payment parity for mental health services made last summer in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Pub. L. 110-275 (July 15, 2008).^[2] Under that law, beginning in 2010, there is a reduction in the cost-sharing related to the treatment of outpatient psychiatric services. By 2014, beneficiaries will pay the standard 20% coinsurance rate for Part B services.^[3]

An Overview of Mental Health Services Coverage under Medicare

- Inpatient Hospital Services

Hospital-based inpatient care is available for mental health treatment under Part A. Inpatient care is health care received when a beneficiary stays in a hospital overnight.^[4] However, Medicare limits coverage for inpatient care in a Medicare-certified specialty psychiatric hospital to 190 days during a beneficiary's lifetime.^[5] Beneficiaries may be able to receive additional mental health care after using the 190-day limit if they are admitted into a Medicare-certified *general* hospital.^[6]

If more intensive outpatient care is the best treatment for a particular beneficiary, Medicare may cover what is known as partial hospitalization treatment. A beneficiary's doctor must verify that a person would otherwise need inpatient treatment. Partial hospitalization treatment is typically performed through hospital outpatient departments and local community mental health centers.

- Outpatient Services

Outpatient Services for mental health diagnosis and treatment are covered under Medicare Part B and consist of services that are usually given outside of a hospital and do not require an overnight stay. Part B also covers physician and therapist services while the beneficiary is still in the hospital, and beneficiaries pay 20% in co-insurance for these charges.

For outpatient mental health treatment, it is important to be aware that there is currently a special, more expensive 50% coinsurance rate for outpatient mental health services such as individual, family, and group psychotherapy, and for therapeutic activity and patient education services that are related to the treatment and follow-up diagnostic services for a mental, psychoneurotic, or personality disorder, rather than the initial diagnosis.^[7] As discussed above, this inequity in payment is being phased out over the next five years.

Prior to receiving mental health services, the beneficiary should confirm that the mental health professional accepts Medicare payment. Also, ask whether the independent mental health care provider will accept Medicare assignment, as this could result in cost savings for the beneficiary. Clinical psychologists and social workers must accept assignment, whereas physicians may choose to refuse assignment and require additional payment from the Medicare beneficiary.^[8]

Mental Health Providers Eligible for Medicare Payment

The following independent mental health providers may be eligible for direct payment from Medicare:

- physicians
- physician's assistants
- clinical psychologists
- clinical social workers
- clinical psychiatric nurse specialists; and
- nurse practitioners with the equivalent of a master's degree in psychotherapy.^[9]

Payment for Psychotropic Medications

Prescription psychotropic drugs are covered for Part D enrollees in private, stand-alone prescription drug plans and for those with drug coverage offered by Medicare Advantage plans through Part C. While each drug plan can decide which drugs to include on its formulary, every plan must include all or substantially all drugs that fall within six protected classes of drugs. Antidepressant and antipsychotic drugs are among the six classes that must be included. However, benzodiazepines and barbiturates, often used as tranquilizing drugs or drugs to treat other mental disorders are currently excluded under Medicare Part D coverage rules.

Conclusion

Mental health is an essential component to overall health. Advocates should continue to work to increase the scope of mental health services covered by Medicare, which should include support services such as transportation, as well as testing and training for job assistance. In addition, advocacy is necessary to reduce the disparity in co-payments applicable to mental health as compared to other healthcare services.

[1] For more information, visit www.mentalhealthweek.org or www.owl-national.org or call 1-800-969-6642 for The Voice of Midlife and Older Women. More useful resources are The National Institute of Mental Health, www.nimh.nih.gov and the Medicare Benefit Policy Manual at <http://www.cms.hhs.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS012673&intNumPerPage=10>. (available only on the internet).

[2] See §102 of MIPPA amending §1833(c) of the Social Security Act, 42 U.S.C. §1395l(c). Note that Congress also enacted the Mental Health Parity and Addiction Equity Act of 2008, which continues existing parity requirements regarding annual and lifetime dollar limits in employer-sponsored insurance and extended parity requirements to substance use disorder benefits. P.L. 110-343 amending 29 U.S.C. § 1185a, 42 U.S.C. § 300gg-5.

[3] *Id.* Beginning in 2010, for expenses reflecting the Medicare approved amount that are incurred in a calendar year in connection with the treatment of outpatient psychiatric services, Medicare will begin to increase the percentage (currently 50 percent) that it will cover as follows: 55 percent of expenses incurred in 2010 or 2011; 60 percent in 2012; 65 percent in 2013; 80 percent in 2014 or in any subsequent calendar year. As explained in this section of MIPPA, "treatment" does not include brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of psychiatric disorders or partial hospitalization services not directly provided by a physician.

[4] 42 U.S.C. §1395x(c). *See Medicare & You: Medicare and Your Mental Health Benefits*, Centers for Medicare & Medicaid Services, 7. www.medicare.gov.

[5] 42 U.S.C. §1395x(f).

[6] Hospital services are measured in benefit periods. Benefit periods begin the day a beneficiary is admitted into a hospital and end after 60 consecutive days have passed during which time the beneficiary has gone without hospital care for the particular condition at issue. There is no limit to the number of benefit periods a beneficiary can have, but a beneficiary must pay a deductible (\$1,068 for 2009) for services in each new benefit period. While no co-insurance is required for the first 60 days, for days 61-90, a beneficiary must pay co-insurance of \$267 per day in 2009. For days 91-150 ("lifetime reserve days"), a beneficiary must pay \$534 per

day in 2009. The lifetime reserve days can only be used once; they are not renewable. For any days over 150, the beneficiary must pay the entire hospital costs.

[7] 42 C.F.R. §410.155. Technically, the Medicare reimbursement rate is 62.5% of the standard Part B reimbursement rate of 80%, resulting in a coinsurance to the beneficiary of 50%. There are a few exceptions that retain the standard 80% reimbursement rate for Part B, including: brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, or personality disorders; partial hospitalization services not directly provided by a physician; diagnostic services, such as psychological testing, that are performed to establish a diagnosis; medical management, as opposed to psychotherapy, furnished to a patient diagnosed with Alzheimer's disease or a related disorder.

[8] Id.

[9] Some providers like licensed professional clinical counselors and marriage and family therapists can provide "qualified psychologist services." The term "qualified psychologist services" means such services and supplies furnished as an incident to his service furnished by a clinical psychologist (as defined by the Secretary) which the psychologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physician's service. 42 U.S.C. §1395x(ii).

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