

Accessing Behavioral Health Services for Older Adults

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Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since 1972 we've focused our efforts primarily on fighting for people who have been marginalized and excluded from justice, such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Key Lessons

- **Many older adults need behavioral health services.** One in five adults age 55 and older and nearly half of individuals dually eligible for Medicare and Medicaid have at least one mental or behavioral health condition. Many older adults have both mental and substance use disorders, along with physical health conditions.
- **Medicare is the main source of behavioral health coverage for older adults.** Medicare covers both outpatient and inpatient behavioral health services as well as prescription drugs for most seniors, but many older adults also rely on Medicaid.
- **People who are dually eligible for Medicare and Medicaid can face additional challenges in accessing behavioral health services.** Lack of integration of behavioral health, medical care, and long-term services and supports, as well as poor coordination between Medicare and Medicaid-funded behavioral health services can create barriers to care. A number of states are experimenting with different ways to better integrate Medicaid behavioral health services with medical and long-term services and supports.

Many Older Adults Need Behavioral Health Services

Access to comprehensive behavioral health services is critical for older adults, as one in five seniors in America has at least one mental health or substance use condition¹ and one in three individuals over the age of 50 report having misused opioid drugs in the last 30 days.² These rates are even higher among the lowest-income older adults, with nearly half of individuals dually eligible for Medicare and Medicaid having at least one mental health condition.³ Moreover, older adults have the highest suicide rate of any age group. The rate among men age 75 and older is nearly double that of any other group.⁴

In addition, many older adults struggle with both mental health and substance use issues. For example, opioid misuse is more common among older adults with past year major depressive episode (MDE) than those without MDE and those with past year alcohol use disorder (AUD) than those without AUD. Mental and

1 Ctrs. for Disease Control & Prevention & Nat'l Assn. of Chronic Disease Dirs., The State of Mental Health and Aging in America (2008), available at [cdc.gov/aging/pdf/mental_health.pdf](https://www.cdc.gov/aging/pdf/mental_health.pdf).

2 Aging in Place, How The Opioid Crisis Affects The Elderly (Updated Aug. 2019), available at aginginplace.org/how-the-opioid-crisis-affects-the-elderly/.

3 Kaiser Family Foundation, Chronic Disease and Co-Morbidity Among Dual Eligibles (2010), available at [kff.org/health-reform/report/chronic-disease-and-co-morbidity-among-dual/](https://www.kff.org/health-reform/report/chronic-disease-and-co-morbidity-among-dual/).

4 Ctrs. for Disease Control & Prevention & Nat'l Assn. of Chronic Disease Dirs., The State of Mental Health and Aging in America (2008), available at [cdc.gov/aging/pdf/mental_health.pdf](https://www.cdc.gov/aging/pdf/mental_health.pdf).

physical health comorbidities are likewise high among older adults and dually eligible individuals.⁵ Among seniors age 65 and older, alcohol is the leading reason for referrals and admissions for substance abuse treatment. Not only are people over age 65 more sensitive to its effects, alcohol can interact dangerously with medications and exacerbate medical conditions common among older adults such as stroke, high blood pressure, diabetes, osteoporosis, memory loss, and mood disorders.⁶

There are significant disparities in the behavioral health needs of older adults. More than half of all Medicare inpatient psychiatric facility patients are duals,⁷ and nearly half of the under 65 dual eligible population have severe mental disorders.⁸ Moreover, opioid use disorder is more prevalent among adults age 50 and older who are living in poverty and who are Hispanic (compared to non-Hispanic whites).⁹ Meanwhile, some research indicates that many older adults of color with mental health disorders do not receive professional help.¹⁰

Medicare is the Main Source of Behavioral Health Coverage for Older Adults

Medicare is the main source of health care coverage for seniors living in the U.S., including behavioral health services. Although Medicare's behavioral health coverage is not comprehensive, it does cover a range of services including screenings, outpatient and inpatient treatment, and prescription drugs.

Under Part B, Medicare covers outpatient mental health services such as screenings for depression and individual and group psychotherapy with doctors or certain other providers. These services may be delivered in a provider's office, a hospital outpatient department, or a community mental health center. Medicare also covers Structured Assessment and Brief Intervention (SBIRT) services provided in a doctor's office or outpatient hospital when an individual shows signs of substance use disorder or dependency.¹¹

As with other Part B services, Original Medicare covers outpatient mental health services at 80% of the Medicare-approved amount, meaning beneficiaries pay 20% coinsurance after meeting their yearly deductible. Medicare Advantage plans must also cover these services but may set their own cost-sharing amounts.

Behavioral health services covered under Medicare Part B

- One depression screening per year. The screening must take place in a primary care doctor's office or primary care clinic that can provide follow-up treatment and referrals.
- Individual and group psychotherapy with doctors or certain other licensed professionals allowed by the

5 CMS. "Physical and Mental Health Condition Prevalence and Comorbidity among FFS Medicare-Medicaid Enrollees" (2014). Table 25, available at [cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidty_2014.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidty_2014.pdf).

6 NCOA. A Spotlight on Older Adults and Behavioral Health, available at d2mkcg26uvvg1cz.cloudfront.net/wp-content/uploads/May-18-Slides-A-Spotlight-on-Older-Adults-and-Behavioral-Health.pdf.

7 Ctr. for Health Care Strategies, Extending Lessons from a Medicaid Pilot to Improve Care for Medicare and Dual Eligible Beneficiaries (Feb. 2013), available at chcs.org/resource/extending-lessons-from-a-medicaid-pilot-to-improve-care-for-medicare-and-dual-eligible-beneficiaries/.

8 Richard Frank & Arnold Epstein, Factors Associated With High Levels Of Spending For Younger Dually Eligible Beneficiaries With Mental Disorders, *Health Affairs* (June 2014), available at [healthaffairs.org/doi/full/10.1377/hlthaff.2013.0769](https://doi.org/10.1377/hlthaff.2013.0769).

9 NCOA, SAMHSA, Nat'l Council on Mental Health & Aging, A Spotlight on Older Adults and Behavioral Health (May 2017), available at d2mkcg26uvvg1cz.cloudfront.net/wp-content/uploads/May-18-Slides-A-Spotlight-on-Older-Adults-and-Behavioral-Health.pdf.

10 Harold W. Neighbors, et. al., Mental Health Service Use Among Older African Americans, *American Journal on Geriatric Psychiatry* (Dec. 2008), available at ncbi.nlm.nih.gov/pmc/articles/PMC4846982/.

11 SBIRT includes a screening (assessment to determine the severity of substance use and identify the appropriate level of treatment), brief intervention (engagement to provide advice, increase awareness, and motivate individual to make behavioral changes), and referral to treatment (if the individual needs additional treatment, provides them with more treatment and referral to specialty care).

state where the services are provided.

- Family counseling, if the main purpose is to help with treatment.
- Testing and evaluation of current treatment.
- Psychiatric evaluation.
- Medication management.
- Certain prescription drugs that are not usually “self administered” such as some injections.
- Diagnostic tests.
- Partial hospitalization.
- A one-time “Welcome to Medicare” preventive visit, including a review of possible risk factors for depression.
- A yearly “Wellness” visit, including an evaluation of changes in mental health.
- Outpatient mental health services for treatment of inappropriate alcohol and drug use.

PRACTICE TIP

Medicare has restrictions on the types of licensed professionals that can deliver services and only covers the services when they are provided by a health care provider who accepts Medicare. Part B covers mental health services provided by a psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, or physician assistant. Medicare does not cover services provided by mental health counselors or marriage and family therapists. This restriction can be a barrier to care for Medicare beneficiaries, especially those living in rural areas where such counselors and therapists may be the only behavioral health providers.

PRACTICE TIP

It is important for beneficiaries enrolled in Original Medicare to verify that a behavioral health provider accepts Medicare prior to making an appointment. Psychiatrists are more likely than any other type of provider to opt out of Medicare. Medicare will not reimburse for services provided by an opt-out provider. However, opt-out providers must require Medicare beneficiaries sign a private contract stating that they do not take Medicare and that the beneficiary must pay the full cost of the service. If an opt-out provider does not obtain this signed contract, the beneficiary is not responsible for the cost of care delivered.

Medicare Part A covers behavioral health treatment in hospitals and psychiatric hospitals, including professional services provided by clinicians that Medicare does not recognize for separate billing, e.g., peer counselors, and medication provided as part of inpatient treatment.¹² Medicare beneficiaries have a lifetime limit of 190 days of inpatient care at psychiatric hospitals.¹³ Individuals who have used their lifetime days may be able to receive additional needed mental health care at a general hospital.

Cost sharing is the same as for other Part A services: after meeting the Part A deductible, Original Medicare pays in full for the first 60 days of a stay in a general or psychiatric hospital. After day 60, beneficiaries pay a

12 Medicare pays providers separately if they are recognized under Part B (e.g., physicians) and the services provided are considered separate from the inpatient stay. See [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1604.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1604.pdf).

13 42 C.F.R. § 409.62.

daily hospital coinsurance. If a beneficiary enters a psychiatric hospital within 60 days of being an inpatient at a different hospital, they do not have to pay the Part A hospital deductible again because it is considered the same benefit period. Medicare Advantage plans may have their own cost-sharing structure but they must cover all services that Original Medicare covers.

Medicare also covers treatment in Medicare-certified Partial Hospitalization Programs (PHPs) for individuals who require a minimum of 20 hours per week of therapeutic services and would otherwise be hospitalized.¹⁴ A PHP is an outpatient psychiatric day treatment program that may be offered through hospital outpatient departments and Community Mental Health Centers.

PRACTICE TIP

Medicare is playing an increasingly large role in opioid misuse treatment. It pays for one-third of opioid-related hospitalizations, making it the single largest payer nationwide. There are some limitations to be aware of. For example, Medicare covers methadone and other Medication Assisted Treatment (MAT) in inpatient hospital settings. However, in outpatient settings, Medicare does not cover methadone but does cover other MAT, including buprenorphine, buprenorphine-naloxone combination products, and extended-release injectable naltrexone under Part B or Part D. Beginning in 2020, certified Opioid Treatment Programs (OTPs) may bill Medicare for methadone MAT as part of a bundled payment under Part B. For dually eligible individuals, state Medicaid Programs may currently cover methadone in their bundled payment to qualified drug treatment clinics or hospitals that dispense methadone for opioid dependence.¹⁵

Medicare Part D prescription drug coverage includes anti-depressants, anti-psychotics, and medically necessary drugs to treat substance use disorder with the exception of methadone or similarly administered medications (Medication Assisted Treatment or MAT).¹⁶ Plans can, however, cover methadone for other conditions, such as pain. For new Part D enrollees, plans must have a transition policy to prevent interruptions in treatment. Part D enrollees can also use the non-formulary exceptions/appeals processes to maintain or gain access to medically necessary prescription behavioral health drugs not on their plan formulary.

People Who Are Dually Eligible for Medicare and Medicaid Can Face Additional Challenges in Accessing Behavioral Health Services

The mental health needs of older adults and persons with disabilities who are dually eligible for Medicare and Medicaid are often overlooked in traditional medical settings, ramping up costs and leading to inadequate care. Lack of coordination between Medicare and Medicaid-funded behavioral health services can create barriers, making it difficult for dual eligibles to access services. Some state Medicaid programs separately carve out the provision of behavioral health services to contracted public or private entities that are distinct from medical and long-term services and supports providers, which can pose an additional challenge.

Medicaid

Medicaid is the largest single payer of mental health services in the United States and increasingly a larger

14 42 C.F.R. § 424.24(e).

15 CMS MLN Matters, Medicare Coverage of Substance Abuse Services (Apr. 2016), available at [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1604.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1604.pdf).

16 This exclusion is because methadone is not a Part D drug when used for treatment of opioid dependence because it cannot be dispensed for this purpose upon a prescription at a retail pharmacy. (A Part D drug is defined, in part, as “a drug that may be dispensed only upon a prescription.” (42 C.F.R. § 423.100)) Note that methadone is a Part D drug when prescribed for pain, and that it may be covered under Part A for inpatients and, beginning in 2020, under Part B through certified opioid treatment programs.

payer for substance use disorder services.¹⁷ As such, it plays a key role in covering and financing behavioral health for low-income Americans, including older adults. All state Medicaid programs are required to cover certain inpatient and outpatient behavioral health services. Other services, like treatment for substance use disorders, rehabilitation services, peer supports, and targeted case management, are optional under Medicaid.¹⁸ Therefore, each state Medicaid agency's exact behavioral health benefit package, i.e., which services are covered, varies.¹⁹ Many states offer some behavioral health services as part of the state Medicaid plan's option to provide other diagnostic, screening, preventative, and rehabilitative care services.²⁰ Services may also be provided through one of the state's waiver authorities. Each state's spending varies, depending on factors like the needs of the population, accessibility of health care facilities and providers, size of the workforce, availability of funding, and more. Accordingly, by state, behavioral health care spending as a proportion of total health spending ranged from 5% in Nevada to 11.7% in Vermont. States who spend more on healthcare overall also tend to allocate a larger share of those dollars to behavioral health.²¹ Medicaid also remains an important payer for treatment of SUDs, especially residential treatment services.

Just as in Medicaid generally, states also structure the administration of specific behavioral health programs in different ways. Some use public or quasi-public state entities to administer services, particularly for populations with serious and persistent mental illness or seriously emotionally disturbed children and youth. Other states administer Medicaid and behavioral health programs together.²² About eleven states “carve out” behavioral health coverage from Medicaid health plans where the services are administered under a separate Medicaid waiver. Unfortunately, carve outs can increase barriers and lead to more uncoordinated care due to fragmentation and related issues.²³ In those states that include behavioral health services within Medicaid managed care plan responsibility, some plans use a subcontractor and others manage the services themselves.

PRACTICE TIP

Understanding the ways in which a state Medicaid agency structures and administers its behavioral health services is key to reducing barriers for dual eligibles who receive both Medicare and Medicaid services. If you are working with a client who is experiencing problems with coordination of behavioral health benefits, consider first checking your Medicaid agency's state plan to see how the benefit is structured. Pay particular attention to whether any carve-outs exist, the possibility of delegation to managed care, and more.

A relatively recent development in Medicaid with respect to behavioral health is the issuance of the Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP.²⁴ The rule generally prohibits health plans and health insurance issuers, including specifically those under Medicaid and CHIP, from imposing less favorable benefit limitations on mental health or substance use disorder benefits than on medical or surgical benefits, applying parity requirements drawn from other health insurance program designs to these programs. The final rule includes detailed parity requirements for Medicaid managed care organizations for states to include in their plan contracts.

17 CMS, Medicaid.gov, Behavioral Health Services, available at [medicaid.gov/medicaid/benefits/bhs/index.html](https://www.medicicaid.gov/medicaid/benefits/bhs/index.html).

18 MACPAC, Behavioral health benefits, available at [macpac.gov/subtopic/behavioral-health-benefits/](https://www.macpac.gov/subtopic/behavioral-health-benefits/); see also 42 U.S.C. § 1396a(g)(2).

19 Kaiser Family Foundation, Medicaid Behavioral Health Services Database Notes and Methods, (2018), files.kff.org/attachment/Survey-2018-Medicaid-Behavioral-Health-Services-Database-Notes-and-Methods.

20 42 U.S.C. § 1396d(a)(13).

21 SAMSHA, Medicaid Handbook: Interface with Behavioral Health Services, (2013) store.samhsa.gov/system/files/sma13-4773.pdf.

22 *Id.*

23 Kim Tuck and Erin Smith, Institute for Medicaid Innovation, Behavioral Health Coverage in Medicaid Managed Care (Apr. 2019), available at [medicaidinnovation.org/images/content/2019-IMI-Behavioral_Health_in_Medicaid-Report.pdf](https://www.medicaidinnovation.org/images/content/2019-IMI-Behavioral_Health_in_Medicaid-Report.pdf).

24 42 C.F.R. §§ 438.900-438.930; 81 Fed. Reg. 18389 (Mar. 30, 2016).

Developments in Behavioral Health for Dual Eligibles

Dual eligibles face issues with the coordination of benefits across Medicare and Medicaid covered benefits, and behavioral health services are no exception. In the shift to better coordinate healthcare delivery for dual eligibles more broadly, some noteworthy developments are pertinent to the delivery of behavioral health services.

In states participating in the financial alignment initiative, otherwise known as dual eligible demonstrations, efforts to better coordinate and integrate behavioral health have been underway. The three-way contracts between the health plan, CMS, and the state Medicaid agency setting forth the details for each state's demonstration typically include provisions to facilitate this type of integration. For example, in California's demonstration, plans are mandated to inquire about behavioral health needs, among others, during an initial enrollment assessment. Plans are also required to coordinate across medical services, behavioral health services, and long term-services and supports.²⁵ Care plans, an integral part of the demonstration, are required to identify behavioral health providers and include their attestation that they have reviewed the plan, if the enrollee is receiving behavioral health services.²⁶ Perhaps most importantly, because California is a state where specialty mental health services are carved out from the general administration of Medicaid benefits and provided by local county entities, plans are required to enter into a memorandum of understanding with those county agencies to coordinate care and share data.²⁷

Massachusetts's demonstration includes a similar focus on integrating behavioral health needs in the plan. In addition to some provisions that mirror California's, its contract also requires plans to ensure timely access to behavioral health services, particularly for enrollees with certain conditions, like a dual diagnosis of mental health and substance use disorder, with an explicit aim to reduce emergency department contact.²⁸

These efforts to coordinate across the spectrum of care—with an explicit inclusion of behavioral health services—are not only in the dual eligible demonstrations. In the Medicare Advantage space, increasing attention is being paid to behavioral health services. For example, a rule released for Medicare Advantage Dual Eligible Special Needs Plans requires that these plans must coordinate with Medicaid behavioral health services and long-term services and supports.²⁹ In promulgating the rule, CMS discussed its expectation for a stakeholder process to develop criteria for a minimum set of coordination requirements, which could include data sharing, timely notifications, and more.

PRACTICE TIP

Advocates in all states have opportunities to encourage their states, health plans, and community mental health agencies to prioritize the mental health needs of older adults. This may mean reviewing and revising [screening mechanisms](#) and referral processes among the different tiers of behavioral health needs. It may mean adopting [best practices](#) from states and community-based organizations with respect to outreach and education strategies regarding individuals with severe mental illness, or ensuring care coordinators at managed care plans are [trained in how dementia and Alzheimer's Disease affect this population](#).

25 California Demonstration, Three Way Contract, 1.55, 2.5.2.1, 2.5.2.8, available at [cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContract01012018.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/CAContract01012018.pdf).

26 *Id.* at 2.5.2.11.7.

27 *Id.* at 2.7.1.2.

28 Massachusetts One Care Demonstration Three-Way-Contract, 2.5.5.8, available at [cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MACContract.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MACContract.pdf).

29 84 Fed. Reg. 15680 (Apr. 16, 2019).

Conclusion

The behavioral health needs of older adults are rising. Integrating behavioral health care with medical care and long-term services and supports is especially critical for older adults. While Medicare covers basic behavioral health services for most older adults, low-income seniors and people with disabilities also rely on Medicaid to meet their needs. Inadequate coordination of behavioral health services between Medicaid and Medicare can be a barrier to care, but promising practices are emerging through demonstrations focused on the dually eligible population.

Additional Resources

- Citations to key statutes governing the topic:
 - » 42 U.S.C. § 1396a(g)(2); 42 U.S.C. § 1396d(a)(13)
- Citations to key regulations on the topic:
 - » Medicare: 42 CFR Parts 409 (Part A hospital insurance benefits), 410 (Part B outpatient benefits & Partial Hospitalization Services), 423 (Part D prescription drug benefits).
 - » [Medicare National Coverage Determinations \(NCDs\) Manual, Chapter 130 Mental Health](#)
 - » 42 CFR § 438 et seq.
- Key federal agency overseeing the subject matter:
 - » [SAMHSA-HRSA Center for Integrated Health Solutions](#)
 - » [Administration for Community Living](#)
- National organizations providing additional resources:
 - » [NCLER Medicare Basics](#)
 - » [National Council on Aging](#)
 - » [National Coalition on Mental Health and Aging](#)

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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