Medicare Coverage of Behavioral Health Services – Frequently Asked Questions

1. What is behavioral health care?

Behavioral health care includes services and programs intended to help diagnose and treat mental health conditions 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 conditions include depression, anxiety, and schizophrenia. Substance use disorders and addiction do not fall under this definition of mental health condition, but they are included under behavioral health conditions. 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. How does Medicare cover inpatient behavioral health care?

Medicare Part A covers inpatient mental health and addiction recovery services that a beneficiary receives in either a psychiatric hospital (a hospital or distinct unit in a hospital that only treats mental health patients) or a general hospital. A beneficiary's provider should determine which hospital setting they need.

If a beneficiary receives care in a psychiatric hospital, Medicare covers up to 190 days of inpatient care in their lifetime. If a beneficiary has used their lifetime days but need additional mental health care, Medicare may cover additional inpatient care at a general hospital.

Be aware that a beneficiary will have the same out-of-pocket costs with Original Medicare whether they receive inpatient care in a general or psychiatric hospital:

- The Part A deductible: Before Medicare covers the cost of inpatient care, the beneficiary has to meet the deductible for the benefit period. In 2026, the deductible is $1,736.
- Days 1-60 of a benefit period: After the beneficiary meets the deductible, Medicare pays in full for the first 60 days of their care.
- Days 61-90 of a benefit period: Medicare pays part of the cost, and the beneficiary is responsible for a daily coinsurance charge. In 2026, the coinsurance is $434 per day.
- Lifetime reserve days: For up to 60 lifetime reserve days, Medicare pays part of the cost, and the beneficiary is responsible for a daily coinsurance charge. The coinsurance in 2026 is $868 per day.

Note that if a beneficiary enters a psychiatric hospital within 60 days of being an inpatient at a different hospital, they are in the same benefit period and do not have to pay the Part A deductible again.

If a beneficiary has a Medicare Advantage Plan, their plan must cover the same mental health and addiction recovery services as Original Medicare, but may impose different costs and restrictions. If a beneficiary needs information about the costs and coverage requirements, or if they are experiencing problems, they should contact their 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:

- Individual and group therapy
- Substance use disorder treatment
- Tests to make sure beneficiary is getting the right care
- Occupational therapy
- Activity therapies such as art, dance, or music therapy
- Training and education (such as training on how to inject a needed medication or education about beneficiary's condition)
- Family counseling to help with beneficiary's treatment
- Laboratory tests
- Prescription drugs that beneficiary cannot self-administer, such as injections that a doctor must give them
- An annual depression screening that a beneficiary receives in a primary care setting. They should speak to their 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.

Original Medicare covers the outpatient mental health and addiction recovery services listed above (with the exception of the annual depression screening, which is covered at 100%) at 80% of the Medicare-approved amount. This means that as long as a beneficiary receives services from a provider who accepts assignment, they will owe a 20% coinsurance charge after they meet their Part B deductible. In the past, Medicare paid a lower percentage of its approved amount for mental health services than for medical/surgical benefits. Federal legislation now requires that mental health benefits not be covered less favorably.

Medicare Part B covers care a beneficiary receives through an outpatient hospital program, at a doctor's or therapist's office, or at a clinic. They 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

A beneficiary should make sure that any provider they see accepts assignment, meaning that they accept Medicare's approved amount as full payment for a service. The providers listed above who are not medical doctors must accept assignment if they accept Medicare payment.

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. A beneficiary should be sure to ask any provider if they take their Medicare insurance before they begin receiving services. If a beneficiary sees an opt-out provider, the provider must have the beneficiary sign a private contract. The contract states that the beneficiary's doctor does not accept Medicare payment and that the beneficiary must pay the full cost of the service. Medicare will not reimburse the beneficiary if they see an opt-out provider. If an opt-out provider does not present the beneficiary with a private contract, the beneficiary is not responsible for the cost of their services.

If a beneficiary has a Medicare Advantage Plan, their plan must cover the same mental health care and addiction recovery services as Original Medicare, but it may impose different costs and restrictions. If a beneficiary needs information about a plan's costs and coverage requirements, or if they are experiencing problems, they should contact their Medicare Advantage Plan.

4. 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, a beneficiary will follow a plan of care tailored to their 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 the beneficiary meet the goals of their plan of care
- Prescription drugs that the beneficiary cannot self-administer
- Training and education closely related to the beneficiary's plan of care
- Family counseling that primarily supports the beneficiary's 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 can be offered by hospital outpatient departments and by community mental health centers. Medicare covers a beneficiary's partial hospitalization care if both of the following apply:

- A doctor certifies that:
  - The beneficiary would otherwise need inpatient treatment, or have recently been discharged from inpatient care and need partial hospitalization to avoid a relapse in their condition.
  - And, less intensive treatment options (such as outpatient therapy) would not be enough to help the beneficiary avoid hospitalization.
- The beneficiary receives 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:

- The beneficiary's provider states that the services are medically necessary
- The beneficiary receives services from a Medicare-approved provider or facility
- And, the beneficiary's provider sets up their 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 6)
  - 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 should cover a beneficiary's care if they 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 a beneficiary is receiving care at an inpatient psychiatric hospital, keep in mind that Medicare only covers a total of 190 lifetime days.

Outpatient care
Part B should cover outpatient care for a substance use disorder that a beneficiary receives 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 a beneficiary receives the service from a participating provider, they will owe a 20% coinsurance after they meet their Part B deductible. If a beneficiary is enrolled in a Medicare Advantage Plan, they should contact their plan for cost and coverage information about treatment for a substance use disorder. Their plan's deductibles and copayments/coinsurance may apply.

Drug coverage
Some medications used to treat substance use do not meet certain requirements for coverage under Medicare Part D. These medications are generally not covered by Part D or Part B. 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 OTP.

6. How does Medicare cover opioid treatment programs?
Effective January 1, 2020, Medicare Part B covers opioid use disorder (OUD) treatment received at 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. Before 2020, Medicare did not cover OTPs, which meant that beneficiaries could not get Medicare coverage for any care they received at an OTP, including methadone treatment.

In order for a beneficiary 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 Medicare beneficiaries. Therefore, beneficiaries who want to get Medicare-covered OTP services should contact the OTP to make sure it accepts Medicare. If the OTP is not enrolled in Medicare, the beneficiary (or other insurance, if applicable) is responsible for the cost of the care.

If a beneficiary has both Medicare and Medicaid and was 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 they meet their deductible, a beneficiary will not owe any cost-sharing (coinsurance or copayment) for OTP.

7. Does Medicare cover drugs needed for mental health care?

To get Medicare prescription drug coverage, a beneficiary 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. A beneficiary should check before joining a Part D plan to ensure that any drugs they need are on that plan's formulary. If their drug is not on formulary, they may have to request an exception, pay out of pocket, or file an appeal to ask the 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).

If a beneficiary has trouble affording their prescription drugs, there may be programs that they can use to save money:

- **Extra Help** is a federal program that helps pay for some to most of the out-of-pocket costs of Medicare prescription drug coverage for people with limited income and assets. Contact Social Security Administration at 800-772-1213 to learn more about eligibility and to apply.
- **State Pharmaceutical Assistance Programs (SPAPs)** are programs that states may offer to help their residents pay for prescription drugs. New York State's SPAP is EPIC (Elderly Pharmaceutical Insurance Coverage) that helps certain Medicare beneficiaries 65 or older pay for prescription drug costs. Visit https://www.health.ny.gov/health_care/epic/ to learn more about eligibility and how to apply.
- **Patient Assistance Programs (PAPs):** A beneficiary may be eligible to get free or low-cost drugs directly from the company that makes them, through a PAP. In most cases, a beneficiary's doctor must apply for you. Not all PAPs allow a beneficiary to apply if they are eligible for Part D. Visit www.needymeds.org or www.rxassist.org to search for PAPs.

8. What is a drug management program?

Beginning in 2019, as a result of the Comprehensive Addiction and Recovery Act (CARA), Medicare Advantage and Part D drug plans will be permitted to establish drug management programs.

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 (see question 6), they cannot use the Extra Help Special Enrollment Period (SEP) to make changes to their coverage. 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 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 when a beneficiary fills 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, the beneficiary may be limited to a seven-day supply or less)

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

10. Where can a beneficiary begin if they need mental health care or addiction recovery services?

A beneficiary can start by contacting their doctor to ask about what services are available, and to ask if the doctor can recommend providers. If a beneficiary has Original Medicare, they can use the Provider Compare tool on www.medicare.gov to find mental health care providers who accept Medicare payment. If a beneficiary has a Medicare Advantage Plan, they can contact their plan to find mental health care providers who are in network and to learn about any costs or restrictions associated with getting care.

If a beneficiary has trouble finding a behavioral health provider, there are a number of national and local resources that can provide assistance.

National

- National Alliance on Mental Illness (NAMI)
  - https://www.nami.org/Find-Support/NAMI-HelpLine
- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - https://www.samhsa.gov/find-help/national-helpline
  - https://findtreatment.samhsa.gov/
- National Suicide Prevention Lifeline
  - 800-273-8255

New York State

- NAMI New York
  - https://www.nami.org/Local-NAMI?state=NY
- Community Health Access to Addiction and Mental Healthcare Project (CHAMP)
  - 888-614-5400

New York City

- NYC Well
  - https://nycwell.cityofnewyork.us/en/
- Department for the Aging (DFTA)
  - https://www1.nyc.gov/site/dfta/services/find-help.page