Building and Sustaining Effective Behavioral Health Care for Older Adults: Strategies and Considerations

November 2022

CENTER
Center of Excellence for Behavioral Health Disparities in Aging

SAMHSA
Substance Abuse and Mental Health Services Administration

E4 CENTER
Center of Excellence for
Behavioral Health Disparities in Aging

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The Engage, Educate, and Empower for Equity: E4 Center of Excellence for Behavioral Health Disparities in Aging **(the E4 Center) measurably advances training and workforce capacity with a specific focus on the community-based implementation of evidence-based practices and programs for vulnerable older adults who experience the greatest behavioral and physical health disparities in the nation.**

The mission of the E4 Center is to engage, empower, and educate health care providers and community-based organizations for equity in behavioral health for older adults and their families. The E4 Center will achieve this through the provision of education, implementation resources, and technical assistance regarding mental health, substance use, and their intersection with physical health. To learn more, please watch the E4 Center video or click here to read more.

Disclaimer: Certain links may not open if using Internet Explorer as browser.

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INTRODUCTION

Welcome!

As part of the E4 Center's mission to engage, empower, and educate health care providers and community-based organizations, we created this toolkit for leaders in diverse care settings who serve or would like to serve older adults. The toolkit highlights key engagement and sustainability strategies that will help advance efforts to improve behavioral health outcomes.

Why focus on behavioral health?

As articulated by the Centers for Medicare and Medicaid Services, "whole-person care" is care that takes into account "the whole of a beneficiary's needs including physical health, behavioral health, long-term services and supports (home and community-based services, and institutional care), and health-related social needs."

Behavioral health, which encompasses an individual's "whole emotional and mental well-being, and includes the prevention and treatment of mental disorders and substance use disorders," merits attention because of how behavioral health symptoms impact people's daily lives as well as their health.

Despite the widespread need for behavioral health care, millions of US older adults receive inadequate or no care at all. Older adults are 40% less likely than younger adults to pursue or engage in mental health treatment, and when they do seek treatment, older adults are less likely to receive adequate services. Substance use, particularly alcohol use, is increasing with the baby boomer generation, yet among older adults with substance use disorders (SUDs), only 28% receive treatment. Members of marginalized communities – including Black and Brown populations, individuals who do not speak English as a first language, individuals of low socioeconomic status, and LGBTQ+ identifying individuals – are less likely to be screened or offered treatment, and less likely to remain engaged in treatment; when they do access care, they frequently receive poorer quality services.

Adverse behavioral health issues may include anxiety, depression, and drug use, among many others. Each of these symptoms can greatly affect health and quality of life. By focusing on improving behavioral health for older adults, we can achieve improved health and quality of life outcomes for all of us as we age.

There are many ways for clinicians and other providers to improve older adult behavioral health outcomes. This prevention framework defines actions that can be taken to prevent behavioral health needs or exacerbation of needs:

	Definition	Examples
Primary prevention	Universal strategies that aim to **promote wellness and create safe and healing environments** for all people. Primary prevention aims to stop disease before it starts, often by reducing or eliminating risk factors.	• Campaign to reduce stigma around mental health, substance use, and aging • Social care activities to minimize social risk factors and address social needs • Trauma-informed care • Addressing social isolation
Secondary prevention	Strategies that aim to **detect and treat disease or its complications at an early stage**, before symptoms or functional losses occur, thereby minimizing morbidity and mortality.	• Screening for depression, alcohol use, or other substance use • Care management and collaborative care initiatives, including Improving Mood—Promoting Access to Collaborative Treatment (IMPACT) • Developing partnerships to address needs (see the E4 Center's recent toolkit, Utilizing Cross-Sector Partnerships to Reduce Behavioral Health Disparities in Older Adults)
Tertiary prevention	Strategies around **management of existing disease to prevent further symptom development and functional loss**.	• Mental health and substance use treatment • Support groups and other programs, such as Alcoholics Anonymous • Evidence-based programs such as Healthy IDEAS and PEARLS

To effectively improve outcomes, any primary, secondary, and tertiary prevention practice needs to do two things. First, it must be effective at meaningfully reaching those in need; and second, it must have the ability to be offered over time. This toolkit will cover both of these things.

This toolkit will cover best practices for meaningfully engaging older adults in care, as well as strategies for financing and supporting the workforce in order to sustain your efforts.

EFFECTIVE ENGAGEMENT OF OLDER ADULTS[1]

Engagement of those you serve is essential to ensure both effectiveness of your services and financial success. If you are growing your program, how will you conduct outreach and recruitment to get older adults in the door? How can you create a welcoming and accessible physical environment to facilitate access to care for everyone, including older adults? What kinds of communications and care models can help improve older adults' experience and enhance accessibility for individuals with functional loss? This section will highlight strategies in each of these domains: outreach and recruitment, welcoming and accessible physical environments, and communications and care models.

Outreach and recruitment

Growing programs to serve older adults requires attention to outreach and recruitment. Recommended strategies for outreach and recruitment include:

Start with learning from and about older adults in the community you're serving, to understand their priorities and challenges related to behavioral health and accessing care. This can include conducting focus groups, interviews, or surveys, and reviewing data on local older adults' behavioral health. For more, see pages 17-19 in the E4 Center's recent toolkit, Utilizing Cross-Sector Partnerships to Reduce Behavioral Health Disparities in Older Adults.

Distribute information at community events and on social media to destigmatize accessing behavioral health care (e.g., sharing videos featuring older adults talking about their behavioral health needs).

Connect behavioral health concerns to current events, such as isolation due to COVID-19 or community violence, to normalize experiences and reduce stigma.

Publicize your services through diverse mechanisms, including non-internet-based platforms such as community newsletters, pamphlets, bulletin boards, local healthcare and dental clinics, and local radio shows.

Proactively work to engage older adults in places they may frequent such as hosting an educational event in the community room of a senior building.

Seek opportunities to reach family caregivers, who may be attuned to behavioral health concerns and changes in the older adults for whom they care.

Build partnerships with providers and organizations that serve older adults and may refer older adults for services, including but not limited to primary care providers. See the E4 Center's recent toolkit, Utilizing Cross-Sector Partnerships to Reduce Behavioral Health Disparities in Older Adults.

Offer in-person outreach by clinicians and staff to show the face of the organization and build a sense of warmth and connection.

Provide transparent information about costs of services, and decrease waiting list times as much as possible.

Offer other activities on site, such as support groups, exercise classes, or computer classes, so there are other reasons people might come to clinic. Alternatively, provide services where older adults already are, such as senior centers or senior residence buildings.

[1]This section resulted from a co-design process with older adult recipients of behavioral health services, conducted in Spring, 2022.

These activities can not only help with initial outreach and recruitment, but also can encourage ongoing engagement in care. One example of an organization that uses on-site programming to foster engagement and social connectivity for older adults is Oak Street Health:

> Oak Street Health is a for-profit network of value-based primary care centers for adults on Medicare, currently operating more than 130 centers across 20 states. The company assumes the full financial risk of its patients and takes an integrated approach to primary care that focuses on treating the whole person – including behavioral, mental and social wellbeing, in addition to a patient's physical health.
>
> Oak Street Health says it "understands the importance of older adults feeling valued and connected," and hosts fitness classes, health seminars, games, arts and crafts and more in its centers' community rooms.
>
> As a result of this approach, according to their 2021 Social Impact Report, patients experienced an average reduction of 5.3 points in Patient Health Questionnaire-9 (PHQ9) depression test scores after six weeks of care. Furthermore, 43% of enrolled patients sustained a reduction of 50% or greater after six months of care.

Accessible and welcoming physical environments

Age, disability, and chronic conditions may affect how older adults and caregivers access and experience care. It is critical – and required by the ADA – to provide "full and equal access" to care for people with disabilities.

The following aspects of your office's physical environment, as detailed in our Age-Friendly Environmental Checklist (Appendix A), are important to review for accessibility concerns:

- Building entrance
- Parking
- Elevator
- Floor plan
- Corridors
- Restrooms
- Signage
- Furniture
- Sound
- Paperwork and forms

In addition to accessibility, older adults emphasize the need for settings to be physically inviting and welcoming. Elements of light, warmth, and restfulness should be integrated into the architecture and design of behavioral health spaces.

Finally, mental health care is increasingly being provided via virtual or audio-only telehealth mechanisms. Telehealth platforms can have positive and negative benefits on accessibility for older adults, as outlined in Tele-Social Care: Implications & Strategies. Clinics should be prepared to provide accommodations or supplemental support, such as technical assistance provided by a staff member or volunteer to assist the older adult joining the telehealth or video conferencing platform. An example guide from Rush's health promotion program Rush Generations is available here. See information about reimbursement for telehealth services below.

Communications and care models

Older adults emphasize a desire for more human connection when interacting with their health care team. As one older adult in our co-design process stated, "we are much more connected and connectable than younger generations. We want to interact with each other and our providers." Human connection can also help bridge the generational and cultural gaps that may exist between patient and provider. Important strategies for incorporating this into your work include:

- First impressions are critical; be mindful that every staff member who interacts with the older adult, from physician to custodian, plays an important role in their experience.
- Greet clients warmly upon arrival or when talking on the phone. One older adult said, ***"If I'm greeted warmly by the person working at the front desk, that might be the highlight of my month."***
- Talk about mental health in plain, non-clinical language.
- Address stigmatizing beliefs held by some older adults that receiving mental health treatment means they are "crazy," "weak," or other stigma-driven beliefs.
- Connect with clients on a human and personal level. As one older adult shared, ***"We become attached to our providers. We see them as people, and we want them to act as people."***
- Be willing to self-disclose some information when invited by the client. One older adult shared an experience of asking how her provider entered the field: ***"She was a black woman, and I felt proud as an older black woman. But her dismissive response of, 'Oh, I don't want to talk about that' was a major turn-off."***
- Foster a collaborative and empowering approach. As one older adult explained, ***"This is the message we want to hear: 'We are entering a collaborative relationship in which I am offering expertise to support you to make the best decisions for yourself.'"***
- Avoid paternalistic, "I know best" tone. As one older adult said, ***"I don't want someone telling me what to do or treating me like a lab specimen."***
- When providing promotional information or referral information, be sure there is direct contact information for an actual person. As an older adult said, ***"Refer me to a person, not a program."***
- Leverage leaders from the community, including those with lived experience of behavioral health issues as trusted messengers, potentially including evidence-based peer support programs such as the Certified Older Adult Peer Specialist program (COAPS).
- Streamline the paperwork and insurance processes to the degree possible.
- With permission from the older adult, collaborate with older adult's health care team as appropriate.
- Make appointment reminder calls with staff, rather than automated systems.

There are also specific strategies that clinicians and staff can incorporate to support individuals with particular health conditions and abilities:

Hearing	• Inquire about hearing ability.
	• Remind individuals who have them to bring their hearing aids to appointments.
	• Use speech conducive to the most common types of hearing loss for older adults (speak clearly and in a low tone; do not shout or over-enunciate).
	• Direct sound toward the patient's stronger ear, if applicable.
	• If you're unsure if the older adult heard you or heard correctly, ask them to repeat what they understood from what you said.
	• Offer:
	  o Transparent masks
	  o Sound amplifying headphones (e.g., PocketTalker)
	  o Sign-language interpreters

Vision	• Identify yourself at the beginning of interactions. • Encourage older adults to wear their glasses or corrective lenses to appointment. • Be aware of and support older adults compensating for visual perceptual deficits, such as right or left side neglect from a stroke. • Provide verbal cues or bright visual anchors along the neglected side of the paper or environment. • Offer information in multiple formats, including large print, Braille, or an electronic format such as a recording.
Cognitive functioning	• When possible, provide extended visits to cognitively impaired older adults. Additional time allows for a slower pace that improves comprehension, and the repetition of critical facts or instruction. • Maintain the individual's attention by saying their name first, during a conversation and before asking a question or giving instruction. • Ensure that only one person speaks at a time. • Be aware that a limited range of affect, facial expression, and emotion may be a neurological symptom rather than a signal of disinterest or depression. • If a caregiver is present, make sure to directly address the older adult, along with speaking to any caregivers. With the older adult's consent, encourage the care partner to provide history, inform recommendations, and support interventions as needed.
Speech and language	• Start with establishing direct eye contact with the older adult. • Support understanding by using notepads or a communication board. • Enhance communication by using gestures, pictures, objects, facial expressions or body language. • If the message that the older adult conveys is unclear, repeat or rephrase what you think they are trying to say. Never pretend to understand a message when you don't. • When necessary, use certified medical interpreters. Do not rely on family members for language interpretation. • Ask about first language and length of time speaking secondary language(s). • Give additional clinical time to older adults with communication issues such as aphasia, dysarthria, and other expressive and receptive speech issues.

Providers and staff interacting with older adults should be trained in working with diverse older adults in both respectful and effective ways, along with best practices for addressing older adults' behavioral health needs.

There are several training resources available to support this skill development, particularly from the E4 Center and CATCH-ON, the Collaborative Action Team training for Community Health — Older adult Network. See Appendix B for a compilation of free training resources.

The E4 Center also maintains an inventory of resources for clinicians and others about ageism, depression and anxiety, serious mental illness, substance use disorders, and Age-Friendly Health Systems, viewable at https://e4center.org/resources/.

SUSTAINABILITY

Sustainability can be defined as "the continuation of activities or benefits for target recipients after an initial period of funding ends or following the initial implementation of a new program or procedure." In more simple terms, it is the ability to offer services over time.

Many factors influence whether an organization is able to offer a program or type of care over time. For instance, the Sustainability Framework and Assessment Tool describes several domains that influence an organization's ability to maintain programming and its benefits over time - including stakeholder engagement, organizational capacity, funding stability, and outcomes & effectiveness.

This toolkit will highlight three important factors influencing program sustainability: understanding impact, funding sources, and workforce.

Understanding impact

As programs are established, monitoring basic process and outcome data allows you to understand successes and challenges facing your program and to identify opportunities for improvement. For example, you might want to know how many clients you served over a certain timeframe, average number of completed sessions, rates of missed appointments, and the distribution of funding sources (sometimes referred to as "payer mix"). You may also want to know how depression and anxiety scores change over time for your clients, and whether that varies by clinician or by client characteristic such as race, age, or preferred language.

Insights from looking at this type of data may uncover opportunities to improve your program's approach or structure. This type of data can also help you articulate your reach and impact. If your staff does not have the skill set to analyze data in this way, consider partnering with a local university.

As demonstrated in a number of studies in diverse settings, addressing older adults' behavioral health needs is associated with improving individuals' behavioral health symptoms as well as fostering improved engagement in health care and reductions in total cost of care. Demonstrating these improvements can aid in future funding options, including grants and contracts, as well as attract older adults and their families to the impact of care you provide. Impact findings include:

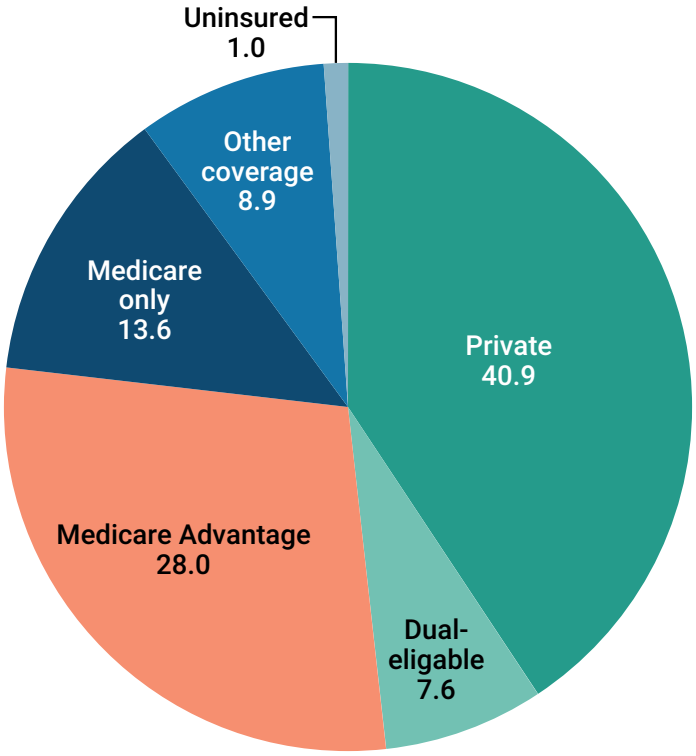
- In one study of older adults with HIV, individuals without access to therapy had an increase in hospital admissions and premature death compared with the group that had access to therapy. Read more here.
- A study of an eight-week telehealth behavioral health intervention for individuals with cardiac health issues found that within six months, program participants had significantly reduced levels of depression, anxiety, and stress; fewer hospital admissions and days in the hospital; and lower cost of care than the comparison group. Read more here.
- In a study assessing the effectiveness of outpatient Assertive Community Treatment (ACT) among older adults who were initially difficult to engage in psychiatric treatment, ACT was associated with increased retention in treatment plans, with a dropout rate of 18.8% compared to 50% in patients who did not participate in ACT. Read more here.
- In one study of older adults with depression and Alzheimer's disease, behavioral treatments that integrated caregivers into patients' care helped to decrease depressive symptoms in both the older adult and their caregiver. Read more here.
- In one randomized controlled pilot study of veterans, an integrative care model was used to coordinate between primary care and mental health clinics. After 12 months, patients treated at the integrated care clinic had more primary care visits and received more preventive services. Read more here.

Funding sources

Diverse funding sources can be sought to support behavioral health work with older adults. Many behavioral health services are reimbursed by health insurance plans, including Medicare and Medicaid. There are also several federal grants run by states that are opportunities for local agencies to get involved, and philanthropic funders can assist as well. Finally, there are special considerations for sustaining cross-sector work.

Types of health insurance

Nearly 50% of older adults have health insurance coverage from Medicare (Medicare only, Medicare Advantage, or dual-eligible for both Medicare and Medicaid), while over 40% of older adults have private health insurance coverage (employer-based or direct-purchase). Other older adults may be covered by Medicaid only, state-sponsored health plans, or military-related coverage such as TRICARE. This toolkit will focus on Medicare and Medicaid.



SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019.

Figure: Percent distribution of health insurance coverage among adults aged 65 and older: United States, 2019. Graphic from https://www.cdc.gov/nchs/data/nhsr/nhsr159-508.pdf

Medicare: Over 50 million Americans are Medicare beneficiaries. US Citizens, as well as lawful permanent residents (i.e., holding a green card) with five years of residency, are eligible for Medicare when they turn 65 or have had a qualifying disability for two or more years. Individuals who have not contributed to social security for ten years or more are eligible, but pay a higher monthly premium for Part A.

Medicare is organized in four "Parts:" A, B, C, and D. There are two core Medicare benefits: **Part A**, generally referred to as hospital insurance, and **Part B**, which covers physicians and most other health services. Beneficiaries with either Part A or Part B coverage can enroll in Part D, the prescription drug benefit, and can also enroll in additional coverage to help with out-of-pocket costs. Beneficiaries also have the option to receive their benefits through managed care, called **Part C**, or "Medicare Advantage Plans". Additional details on Medicare structure and coverage are in Appendix C.

Medicaid is an important source of health and long-term care coverage for low-income older adults and people with disabilities. States have different eligibility criteria for Medicaid, but generally income thresholds for older adults vary from 74% to 100% of the Federal Poverty Level. Approximately 8.5 million adults age 65+ are Medicaid beneficiaries, many of whom are low-income individuals who are also enrolled in Medicare. Illinois and California offer Medicaid-like coverage to older adults regardless of immigration status.

It's also important to note that for people with severe mental illness (SMI), many challenges of aging begin at 50 and older, including high rates of chronic health conditions, disability, and nursing home admission. Additionally, the life expectancy of adults with SMI is between 11 and 30 years fewer compared to the general population. However, these individuals are not eligible for Medicare until they are 65 years old or have received Social Security Disability Insurance for at least two years – and that is if they have paid Medicare taxes for 10 or more years. Because of this, it is also important for clinicians dedicated to improving older adult behavioral health to accept Medicaid.

Dually-eligible older adults: Medicare beneficiaries who are enrolled in partial or full Medicaid are often referred to as "dually eligible" or "duals." All dually-eligible beneficiaries receive the standard package of Medicare benefits, but they may receive different types of Medicaid benefits. Most receive full Medicaid benefits (71%) in their state, and are known as full-benefit dually eligible beneficiaries. Others (29%) have higher income or assets than their state's Medicaid eligibility threshold but still under 200% of the Federal Poverty Level; these individuals are known as partial-benefit dually-eligible individuals and receive assistance through Medicare Savings Programs (MSPs); although they receive assistance with Medicare out-of-pocket costs, these individuals do not qualify for full Medicaid benefits from their state, such as long-term care services and supports or behavioral health services. Partial duals are considerably more likely than the broader Medicare population to have mental health needs such as depression, anxiety, bipolar disorder, and schizophrenia.

Traditional Medicare

"Original" or "Traditional" Medicare covers over 34 million individuals. This section describes out of pocket cost associated with Traditional Medicare, coverage, and billing details relevant to behavioral health, and frequently asked questions from providers new to Medicare.

Out of pocket costs

Traditional Medicare has cost sharing, meaning that beneficiaries pay monthly premiums and co-insurance. Details on out-of-pocket costs are outlined in Appendix C.

Rates change each year, but in 2022, beneficiaries pay $170.10 each month for a premium and are also subject to covering 20% of the cost of most Part B services. For instance, according to Medicare's 2022 fee schedule, a 45-minute psychotherapy session has a national base price of $102.78. The clinician would be reimbursed 80% of this by Medicare (via the state's Medicare Administrative Contractor) and the remaining 20% would be billed to the patient (in this example, $20.56) or secondary insurer. Note that there is no cost sharing for preventive services and that there is zero co-payment for services furnished at Opioid Treatment Programs under Traditional Medicare.

Additional coverage may be provided by:

- Beneficiaries can have privately-paid **Medicare Supplement plans (also called "MediGap")**, which are regulated plans offered by private insurance companies that cover various types of out-of-pocket costs in exchange for a monthly premium.
- Beneficiaries who are eligible for **Medicaid** in their state can generally have most or all of their out-of-pocket costs covered by Medicaid. For Medicare-covered services, such as psychotherapy, Medicare pays first and then Medicaid is billed as a secondary insurance. States' Medicaid coverage of Medicare co-insurance varies, so it is important to understand your state's rules.
- Beneficiaries who are not eligible for Medicaid in their state may still be eligible for **Medicare Savings Programs (MSPs)**, which are Medicaid-administered programs for people on Medicare who have limited income and resources. There are four different MSPs, described in further detail here, each with different income and resource eligibility limits. Each offers different levels of assistance with Part A and Part B out-of-pocket costs.

Many Traditional Medicare beneficiaries are also enrolled in a Part D plan for prescription drug coverage, which have monthly premiums and typically also have annual deductibles and copayments for each prescription. Beginning in 2025, the maximum amount beneficiaries will have to pay out of pocket for prescription drugs will be $2,000 per year. Beneficiaries who qualify for Medicaid or a state MSP automatically qualify for a program called Extra Help (also known as the Low-Income Subsidy program) to help pay for Part D out-of-pocket costs.

Locally, State Health Insurance Assistance Program (SHIP) offices can help Medicare-eligible individuals understand what supports they are eligible for and which specific plans could minimize their out-of-pocket costs. Services are free and objective (i.e., not provided by a specific insurance company). Find details on local SHIP chapters here.

Coverage of behavioral health services

Medicare covers many mental health services on a fee-for-service basis, based on clinical necessity. Covered services include inpatient and outpatient care (such as depression screening, medication management, and individual and group therapy). In some cases, Medicare may cover Partial Hospitalization programs (structured programs provided during the day as an alternative to inpatient care). Medicare covers depression screening with no out-of-pocket costs as part of annual visits by primary care providers (learn more here). Medicare-covered services are summarized in Appendix C (Figure D), and a comprehensive guide is available here.

Medicare recognizes select providers as eligible to provide mental health services when permitted under state law. Specifics about coverage and payment criteria for each of these provider types are detailed here, beginning on page 8 of the CMS document. Note: Medicare does NOT currently cover treatment billed directly by Licensed Professional Counselors (LPCs) or licensed Marriage and Family Therapists (MFTs). However, these independently licensed professionals may qualify as auxiliary personnel who are eligible to provide services "incident to" the personal professional services of a physician or certain nonphysician practitioners if all of the "incident to" requirements are met. While physicians and certain nonphysician practitioners who are authorized to bill the Medicare program for mental health services can be based in diverse settings such as hospitals, Federally Qualified Health Centers, private practices, and Community Mental Health Centers, availability of Medicare payment for their personal professional services versus those services provided "incident to" their services in these diverse settings varies. For example, Medicare does not make separate payment for "incident to" services in the hospital setting. Services provided exclusively by trainees (no licensed Medicare provider in the room) are not eligible for Medicare reimbursement, even under "incident to" policy.

Part D Prescription Drug plans cover certain protected mental health treatment drug classes, including antipsychotics, antidepressants, and anticonvulsants. Medicare Drug plans must cover most medications in these drug classes, with some exceptions. Part B covers some medications that patients cannot self-administer.

While Medicare helps pay for many benefits, it is not subject to the Mental Health Parity and Addiction Equity Act. There are coverage limitations that are important to be aware of, including:

- Medicare currently has a lifetime limit on inpatient days in psychiatric hospitals (190 days).
- Medicare does not cover the full continuum of services recognized by the American Society of Addiction Medicine (with limited coverage of intensive outpatient programs, partial hospitalizations, and residential treatment).
- Medicare does not cover services provided within community-based substance use disorder treatment settings.

The Medicare Addiction Parity Project is one example of an advocacy initiative to advance legislation and regulations to address these gaps.

Billing considerations

Frequently asked questions related to Medicare billing include:

Q: How do clinicians enroll as Medicare providers?	**A: Use the online National Plan & Provider Enumeration System** In order to enroll as a provider, individual clinicians must obtain their own National Provider Identifier (NPI), which is issued through the National Plan & Provider Enumeration System (NPPES). Learn more here. When enrolling, providers choose between three types of relationships with Medicare: • **"Participating" provider:** Clinician who agrees to "accept assignment" for all Medicare-covered services provided to patients. By accepting assignment, the clinician agrees to accept Medicare-allowed amounts as payment in full and to not collect more from patients than the Medicare out of pocket costs. • **"Non-participating" provider:** Clinician who accepts Medicare but does not agree to take assignment in all cases (they may on a case-by-case basis). This means that while non-participating providers have signed up to accept Medicare insurance, they do not accept Medicare's approved amount for health care services as full payment. • **"Opt out" provider:** Clinician who does not accept Medicare at all and has signed an agreement to be excluded from the Medicare program. "Opt out" providers do not bill Medicare. Providers can enroll initially any time of the year, and each Fall there is an open enrollment period when providers can decide whether they want to participate in Medicare for the upcoming year. Institutions such as hospitals and skilled nursing facilities may bill Medicare for services under an organizational NPI, rather than individual health care providers. Individual and institutional applications are available via the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). There is an application fee for institutions (in 2022, $631). Enrollment is managed by Medicare Administrative Contractors (MACs; see next question), and your MAC may have additional requests for information while they process your application. You can also check in with your MAC regarding your enrollment status.

Q: Where do I learn more about billing processes?	**A: Ask your Medicare Administrative Contractor.** Medicare operations are managed by independent contractors known as fee-for-service contractors, or Medicare Administrative Contractors (MACs). MACs manage provider enrollment and process Medicare Part A and Part B medical claims. They also establish regional policy guidelines, called Local Coverage Determinations (LCDs), about whether to cover a particular item or service. MACs also provide official educational resources for providers regarding Medicare billing in your state. A list of MACs organized by state is here.
Q: What settings can behavioral health services be provided in?	**A: Many settings.** Medicare recognizes behavioral health services provided within numerous settings, including clinics, outpatient hospitals, partial hospitalization programs, and Certified Community Behavioral Health Clinics (CCBHCs). Some settings are qualified as "facilities," and some are "non-facility;" some services have separate rates for physicians' services when provided in facility and non-facility settings. Each billing claim must indicate the "Place of Service" describing the type of care setting where the service was rendered (e.g., Office is code 11). The Place of Service code helps determine whether the "facility" or "non-facility" rate is paid. Services provided in hospital outpatient settings (POS codes 19 and 22) receive the facility rate.
Q: How do I learn more about reimbursement rates?	**A: Search the Physician Fee Schedule.** An updated Medicare Physician Fee Schedule (PFS) is released each fall with the reimbursement rates for specific CPT billing codes. The Medicare PFS pricing amounts are adjusted to reflect the variation in practice costs from area to area. Payment information for single or multiple billing codes is available here. It is important to note that psychologists receive 85% of the PFS amount, and clinical social workers receive 75% of the PFS amount.
Q: Is telehealth covered? What about audio-only services?	**A: Yes, with guidelines.** Learn more about general telehealth coverage and requirements in Medicare here. Telehealth policy has evolved significantly in recent years due to the public health emergency. Although the option of video telehealth must be offered, behavioral health services can be billed when provided via telehealth using audio-only communication with established patients located in their homes. Learn more here.

Q: What does "incident to" mean, and when is it used?	**A: "Incident to" refers to a specific staffing and billing arrangement.** Under the Medicare Part B program, physicians and certain nonphysician practitioners (NPPs) can be paid for services that auxiliary personnel provide, in certain situations. This arrangement is called "incident to" billing. The "incident to" benefit category under Medicare law enables those who qualify as auxiliary personnel to provide services that are part of the treatment plan and the services that physicians and certain NPPs furnish to patients. These auxiliary personnel staff must be practicing within their own scope of practice. "Incident to" provisions are authorized under the Medicare benefit category for physicians, clinical psychologists, nurse practitioners, clinical nurse specialists, certified nurse-midwives and physician assistants. The physician or NPP who supervises the auxiliary personnel bills and is paid directly for their own services and incidental services as if they furnished all of the services. To qualify for payment under the "incident to" rules, services must be part of the patient's normal course of treatment, during which the billing provider personally performed an initial service and remains actively involved in the ongoing course of treatment. The services provided must be integral to the billing practitioner's professional services. Services must be within the scope of practice of the employee providing the service. The supervision standard of "incident to" requires "direct supervision" from the billing provider or another supervising provider; this means they must be present in the office suite and immediately available to provide assistance and direction throughout the time the employee is performing the services. However, there are exceptions to this direct supervision level requirement that allow for general supervision of auxiliary personnel by physicians and certain NPPs. For an understanding of all of the program definitions and requirements pertinent to the "incident to" benefit category, see Federal regulations here. For further interpretation of the "incident to" regulations, see program instructions at Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 60 – 60.4.
Q: Are there any reimbursement opportunities for care to integrate behavioral health and medical care?	**A: Yes.** Behavioral Health Integration (BHI) services are reimbursed by Medicare for physicians and non-physician practitioners who integrate behavioral health care and primary care. There are billing codes that describe general BHI services, as well as codes that are specific to the collaborative care model that includes a behavioral health care manager and a psychiatrist available for consult by the primary care provider.
Q: What are "add on" codes?	**A: Additional codes used in combination with a principal service billing code.** There are "add-on" codes for specific services that can be provided only in combination with other diagnostic evaluation, psychotherapy, group psychotherapy, or Evaluation / Management services. Add-on codes identify an additional part of the treatment above and beyond the principal service, such as interactive complexity (e.g., the patient can only communicate in writing or using a communication board) or crisis. Both the principal service code and add-on code should be listed on the billing form.

Finally, the Medicare program adjusts how it reimburses psychiatrists and other clinicians under the Quality Payment Program's Merit-based Incentive Payment System (MIPS) program. Under MIPS, eligible clinicians or clinician groups' performance is assessed via measures across several categories: quality, promoting interoperability, cost, and improvement activities. Several of these metrics have to do with mental health care. Based on this performance, clinicians or clinician groups then have their payment rates adjusted for a future year; payments may be increased or decreased depending on how an eligible provider has performed against national benchmarks. MIPS applies primarily to larger providers that exceed the MIPS low-volume threshold; many individual practitioners or smaller practices need not participate in MIPS. MIPS is one effort to transition providers in traditional Medicare closer to value-based care incentives.

Medicare Advantage

Nationwide, over 17 million Medicare beneficiaries have chosen to receive their Medicare benefits from a private health insurance plan, i.e., via Medicare Advantage. Beneficiaries enroll in plans during Medicare Advantage annual open enrollment period each winter (January 1 – March 31) and are able to change plans or switch back to Traditional Medicare during that time.

Coverage and costs

At a minimum, Medicare Advantage plans cover services that Parts A and B cover. In addition to providing all Medicare Part B covered mental health services, Medicare Advantage plans may offer supplemental benefits that Traditional Medicare does not cover – such as telehealth benefits beyond what Part B pays, medically-approved non-opioid pain management, transportation, or workshops on coping with life changes.

Medicare Advantage beneficiaries must pay monthly premiums associated with Parts A and B and may have an additional monthly premium. Copays and coinsurance amounts vary depending on the plan. Providers and services typically must be in-network to have plan coverage, and typically require referrals and prior authorizations before services can be rendered. Each plan's Evidence of Coverage (EOC) includes details about what is covered and what beneficiaries must pay. Mental health care services with MA plans are categorized as "Inpatient Mental Health Services" (correlating to traditional Medicare Part A) and "Outpatient Mental Health Services" (correlating to traditional Medicare Part B).

Billing

It is important to be familiar with some considerations related to billing Medicare Advantage plans:

- Provider groups negotiate rates with Medicare Advantage plans and typically bill them on a fee-for-service basis using CPT codes. Contracts are negotiated annually and align with calendar years. Agreed-upon rates may reimburse more or less than the Physician Fee Schedule rate under traditional Medicare and are often less than negotiated rates with commercial health plans. Read more on this here.
- If you are an out-of-network provider for a Medicare Advantage plan, most plans (HMOs) do not provide coverage for out-of-network services unless an emergency or urgent situation. In that situation, you bill the beneficiary directly for the same amount that would be billed for a Traditional Medicare beneficiary (based on whether you are a participating provider, non-participating provider, or an opt-out provider). Some Medicare Advantage plans (PPOs) do offer coverage of out-of-network visits, in which case the provider bills the beneficiary directly and the beneficiary submits the bill for reimbursement from the plan.
- Medicare Advantage plans have varying network rules that may affect access to coordinated care. It is important to note that plans often "carve out" mental health care from contracts with health systems, such that primary care at a given organization may be in-network while psychotherapy at the same organization is out-of-network. This is a significant barrier to providing integrated care.

Medicaid

States may choose how to finance the delivery of Medicaid benefits to beneficiaries using a fee-for-service (FFS) model, through Medicaid managed care organizations (MCOs), or a combination of the two. States administer their own Medicaid program, including provider enrollment and billing processes. Learn more here.

Medicaid covers a range of medical and long-term services and supports (LTSS), many of which are not covered at all or only available in limited amounts through private insurance or Medicare. Each state develops its own Medicaid program by establishing state-specific eligibility criteria, provider delivery systems, payment policies, and benefit packages within federal requirements. Federal requirements mandate states to cover a number of benefits, including inpatient and outpatient hospital services, non-emergency transportation to medical care, home health services, and nursing facility services. Individual states can modify their program through state plan amendments and waivers to effectively address local needs and incentivize the testing of new delivery and payment models.

Medicaid also is an important source of financing for behavioral health services, paying for 21% of SUD services and 25% of mental health services as of 2014. Federal law mandates Medicaid coverage of some behavioral health services, such as Medication Assisted Treatment (MAT). In addition to the mandatory services, states may choose to cover additional optional behavioral health services, such as case management, individual and group therapy, detoxification, peer supports, psychosocial rehabilitation and medication management. Most of these behavioral health services are provided under the rehabilitative services option of the state plan. In addition, under optional waiver or state plan authority, states can provide home and community-based long-term care behavioral health services that support independent community living, such as day treatment and psychosocial rehabilitation services.

While all states that participate in Medicaid must cover inpatient services, federal law prohibits payment for services provided in "institutions for mental disease" (IMDs; psychiatric hospitals or other residential treatment facilities that have more than 16 beds). The IMD payment exclusion applies to Medicaid enrollees ages 21 through 64, but states have the option to cover IMD inpatient hospital and nursing facility services for those age 65 and older. Note that states also have the option of pursing a 1115 waiver that allows for a limited exception to the IMD exclusion, and that managed care organizations can cover a 15-day IMD stay in lieu of covered services.

Grants

Many behavioral health initiatives run by non-profit organizations are supported by philanthropic or governmental grants. While incredibly useful in filling gaps, the cyclical nature of grant-funded initiatives can make it difficult to sustain offerings year after year. Grant funds are particularly helpful in demonstrating proof of concept and getting buy-in from healthcare entities that might invest in an initiative.

There are numerous philanthropic foundations that might be interested in funding work to provide behavioral health-related care for older adults. Many such foundations are members of Grantmakers in Aging.

One governmental grant opportunity related to addressing behavioral health needs is the Administration for Community Living's Title III-D program, which provides grants to states and territories based on their share of the population aged 60 and older, to support programs that support healthy lifestyles and promote healthy behaviors. Title III-D-funded programs include programs focused on addressing symptoms of depression and substance use. Funding is distributed through state units on aging. Learn more here. Another program is the Title XX Social Services Block Grant, which provides grants to states and territories to address local priority areas, such as helping individuals to plan for how to stay in their homes as they require more care to be safe.

SAMHSA also funds mental health and substance use services via block grants to states and territories. These include the Community Mental Health Services Block Grant, which supports comprehensive community mental health services for adults with serious mental illness and children with serious emotional disturbances, and the Substance Abuse Prevention and Treatment Block Grant, which focuses on substance abuse prevention and substance use disorder treatment and recover support services. The grant funds are then used by state agencies to fund local service provision across the state.

Supporting cross-sector initiatives

As described in The E4 Center's toolkit focused on cross-sector partnerships, collaboration between health care, behavioral health, and social care providers is critical for improving behavioral health among older adults.

However, planning and carrying out such cross-sector initiatives requires financial support. Many activities under cross-sector partnerships include direct services that are billable or could be sustained via investments under value-based care. However, administrative activities associated with cross-sector partnerships such as creating protocols, monitoring referrals and other deliverables, and managing special projects take time to be done well.

One common challenge for new cross-sector programs is ramping up referrals and ensuring staff are available to respond to referrals in a timely fashion. Seed funding or grant funding to support project launch and piloting can be useful before having to rely immediately on billing to support staff time.

As outlined in The E4 Center's toolkit on cross-sector partnerships, these partnerships can be funded in a few ways:

1. **Independent sources of funds:** Each partner may fund their participation through separate resources.
2. **Shared grants:** Partners might share governmental or philanthropic grants that support partnership activities and services. In this situation, there typically needs to be one lead grantee; the others typically write a letter of support, and have a sub-contract with the main applicant.
3. **Service contracts between partners:** Financial support varies based on completed activities and services. Formal agreements between partners define the amount of support provided via government or private fee-for-service contracts, or insurance reimbursement. In this situation, typically the healthcare entity is able to bill for services (such as behavioral health integration CPT codes) that allows them to reimburse a contracted partner who assists with delivery, or they invest a set amount per service provided with the belief that the service will help their bottom line or improve outcomes from a value-based care lens (given some of the savings cited above).

   Example of a service contract between partners: Elder Services of Merrimack Valley and the Northeast Independent Living Program are contracted to provide care coordination by an Accountable Care Organization. To best ensure that the work of the partnership advances the goals of improved health outcomes, the team identified specific quality measures along with targeted improvement rates for each measure, including initiation of alcohol or other drug of abuse or dependence treatment, and engagement of alcohol or other drug of abuse or dependence treatment. Learn more here.

4. **Risk-Sharing or Outcomes-Based:** Partnership funding is partially or fully based on results. Partners may receive payments based on value, quality metrics, patient outcomes, and/or performance through Accountable Care Organizations, pay-for-performance, or other incentive-based payment models. In this situation, the entire partnership may be subject to payment based on results – both the main healthcare entity as well as any contracting providers and organizations.

One innovative example of funding a cross-sector collaboration took place in New Hampshire:

New Hampshire's Referral, Education, Assistance and Prevention Program (REAP) is a state-wide educational, wellness, and brief mental health and substance misuse program for older adults. REAP counselors provide free services to older adults, caregivers, and professionals throughout New Hampshire within community-based settings (e.g., at home and in senior centers). Services include individual and family counseling; group education for older adults in community settings; and technical assistance to professionals, such as senior center staff, who provide services to older adults and their families.

REAP counselors are subcontracted through New Hampshire community mental health centers (CMHC) and hold either bachelors or masters degrees. A program director, program coordinator, and multi-stakeholder workgroup oversee the program.

REAP is financed through a blended funding arrangement from four state sources: the New Hampshire Housing Finance Authority, and three program areas within the Department of Health and Human Services (The Bureau of Drug and Alcohol Services, the Bureau of Elderly and Adult Services, and the Bureau of Behavioral Health). By spreading funding across four agencies, participants are not billed for screening or outreach, eliminating a barrier to program participation.

Learn more here.

Workforce sustainability

Finally, another critical part of sustaining behavioral health services for older adults is focusing on maintaining a team of clinicians and others who make the care possible. Like with serving any population, offering high-quality behavioral health care to older adults is dependent on an engaged and skilled workforce.

SAMHSA's Evidence-based Resource Guide: Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies discusses six organizational factors—workload, control, reward, community, fairness, and values—that contribute to burnout. Organizational initiatives to engage and support your workforce can include:

- Provide clinical supervision
- Attend to and foster joy in work
- Provide continuing education and professional development opportunities
- Provide adequate compensation for clinicians
- Anticipate and address burn-out
- Provide opportunities for clinicians to practice self-care and other supportive policies

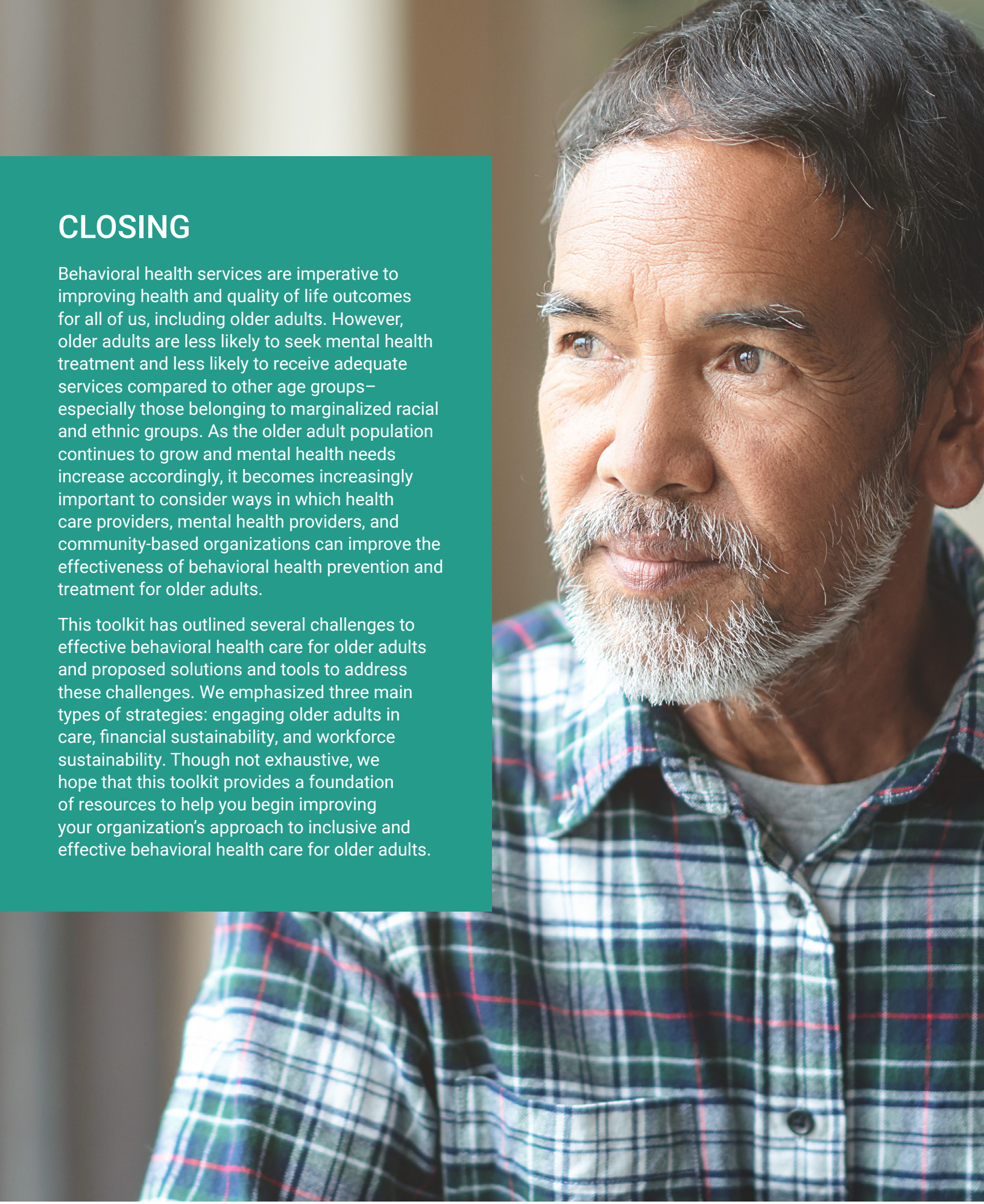
These activities may be particularly important in organizations serving medically and psychiatrically complex older adults with high care needs. The nature of behavioral health care - which often involves helping individuals manage mental health issues, substance use issues, trauma, or behavioral health crises - can be emotionally taxing. As a result, many behavioral health clinicians experience high levels of work-related stress, relatively low salaries, high student debt, and full caseloads. These combined factors place individuals working in the behavioral health field at high risk for experiencing burnout.

Many advocates have highlighted the growing mismatch between insurance reimbursement rates for mental health care and salary expectations for highly-trained professionals, with some organizations that bill Medicare and Medicaid in particular needing to find additional funding sources to bridge the gap. Long-term, increasing reimbursement rates for mental health clinicians will help bolster workforce recruitment and retention.

CLOSING

Behavioral health services are imperative to improving health and quality of life outcomes for all of us, including older adults. However, older adults are less likely to seek mental health treatment and less likely to receive adequate services compared to other age groups–especially those belonging to marginalized racial and ethnic groups. As the older adult population continues to grow and mental health needs increase accordingly, it becomes increasingly important to consider ways in which health care providers, mental health providers, and community-based organizations can improve the effectiveness of behavioral health prevention and treatment for older adults.

This toolkit has outlined several challenges to effective behavioral health care for older adults and proposed solutions and tools to address these challenges. We emphasized three main types of strategies: engaging older adults in care, financial sustainability, and workforce sustainability. Though not exhaustive, we hope that this toolkit provides a foundation of resources to help you begin improving your organization's approach to inclusive and effective behavioral health care for older adults.



APPENDICES

Appendix A: Age-Friendly Environmental Checklist

Environmental Element	Response	Comment
Do stairs and ramps have railings?	YES/NO	
Are doors light enough for ease of use?	YES/NO	
Are doors and hallways wide enough for wheelchairs?	YES/NO	
Are all areas wheelchair and all-gender accessible to allow for caregiver assistance, including restrooms?	YES/NO	
Is there dedicated parking for disabled near the main entrance?	YES/NO	
Are elevators available for every floor?	YES/NO	
Are elevator doors easy to identify?	YES/NO	
Are elevator buttons reachable and well-lit, with the floor marked visibly?	YES/NO	
Is the reception desk easily identifiable from the entrance?	YES/NO	
Is the reception desk low enough for a wheelchair?	YES/NO	
Are all rooms older adults would access large enough for a wheelchair or walker and a companion?	YES/NO	
Are floors non-slippery?	YES/NO	
Is the lighting bright enough with limited glare?	YES/NO	
Are all signs non-glare?	YES/NO	
Is text high contrast from background (e.g., black on white)?	YES/NO	
Is text on signs large print?	YES/NO	
Are pictures available on signs for non-English speakers and cognitively impaired individuals?	YES/NO	
Are signs visible from wheelchairs?	YES/NO	
Do chairs have arms and no wheels?	YES/NO	
Is any music/TV low enough for older adults to hear conversation or call to desk; are headphones available for older adults to listen to TV if health education videos are displayed?	YES/NO	
Are areas where older adults communicate private information to allow for privacy and louder voices?	YES/NO	
Are amplification or TDD devices available?	YES/NO	
Is all paperwork available in 14-point font or larger?	YES/NO	
Does paperwork have strong visual contrast (e.g., black on white)?	YES/NO	

Adapted from:

World Health Organization (2008). Age-friendly Primary Health Care Centres Toolkit. Geneva, Switzerland: World Health Organization.

Godfrey, D., Buenavista, A.L., & Valdenaire, D. (2013). Making Your Office and Beyond Accessible to Your Clients with Intentional "Elder Friendly" Design. American Bar Association.

Appendix B: Training resources

This Appendix lists a number of training resources for clinicians as well as non-clinical staff that will

Webinars on older adult behavioral health	• *For clinicians and non-clinical staff* • Monthly webinars on various topics related to older adult behavioral health, viewable for free at https://e4center.org/webinars/
Evidence-based practice workshops	• *For clinicians* • Evidence-based practice workshops, such as a series on Culturally-Responsive Cognitive Behavioral Therapy (CBT) with Older Adults, viewable at https://bit.ly/3pbS80w
Foundational Competencies in Older Adult Mental Health	• *For clinicians* • 15-hour curriculum on foundational competencies in older adult mental health among mental health clinicians
Older Adult Mental Health 3-Day Intensive Certificate Program	• *For clinicians* • Designed for generalist licensed mental health clinicians, this intensive certificate program, offered in Chicago, provides essential training in late-life mental health issues. Experts in geriatric psychiatry, geropsychology, neuropsychology, and clinical social work collaboratively facilitate this fellowship that is based on the most current evidence-based practices. Content is designed to be applicable across multiple disciplines and settings.
A La Carte Core Knowledge and Skills in Working with Older Adults	• *For clinicians and non-clinical staff* • CATCH-ON provides free online modules, with offerings tailored for clinicians, non-clinical staff, and older adult community members. Viewable at https://catch-on.org/hp-home/hp-education/#virtual. • Topics include: o Understanding normal Aging o Managing Multiple Chronic Conditions o Health Care Teams o Basics of Communicating with Older Adults o Communicating about Multiple Chronic Conditions o Communicating in Health Care Teams o Caregiving o Medication o Mobility o Depression o Dementia o Delirium o Evaluating Memory Concerns o Treatment of Behavior Changes in Persons with Dementia o Person-Centered Care o Cultural Humility and Bias Training

Working Effectively with Diverse Older Adults	• *For clinicians and non-clinical staff*
	• Online training resources include:
	  o National Institute on Aging / Implicit Bias training provided through UCLA Diversity Equity and Inclusion. Training to unpack the attitudes toward people without conscious awareness. Available at https://www.nia.nih.gov/research/alzheimers-dementia-outreach-recruitment-engagement-resources/implicit-bias-resources
	  o Administration on Community Living (ACL) Resources on Diversity and Cultural Competency. Available at https://acl.gov/programs/strengthening-aging-and-disability-networks/diversity-and-cultural-competency including Toolkit for Serving Diverse Communities
	  o American Psychological Association webinar, "How to Better Address Racism-Related Stress in African American Older Adults". Available at https://www.youtube.com/watch?v=DqvF_7O0lSY
	  o National LGBT Health Education Center webinar on LGBTQIA+ older adult health disparities associated with social isolation, HIV and aging, and cognitive decline. https://www.lgbtqiahealtheducation.org/courses/lgbtq-aging-change-challenge-and-resilience-2020/
	  o National LGBT Health Education Center webinar, "LGBT Aging 101: What You Need to Know About Lesbian, Gay, Bisexual & Transgender Older Adults and Caregivers". https://www.lgbtqiahealtheducation.org/courses/lgbt-aging-101-what-you-need-to-know-about-lesbian-gay-bisexual-transgender-older-adults-and-caregivers/

Appendix C: Medicare structure and coverage

Figure A. Medicare structure

Adapted from https://www2.illinois.gov/aging/ship/Documents/NorthernCentralMedSupWeb.pdf

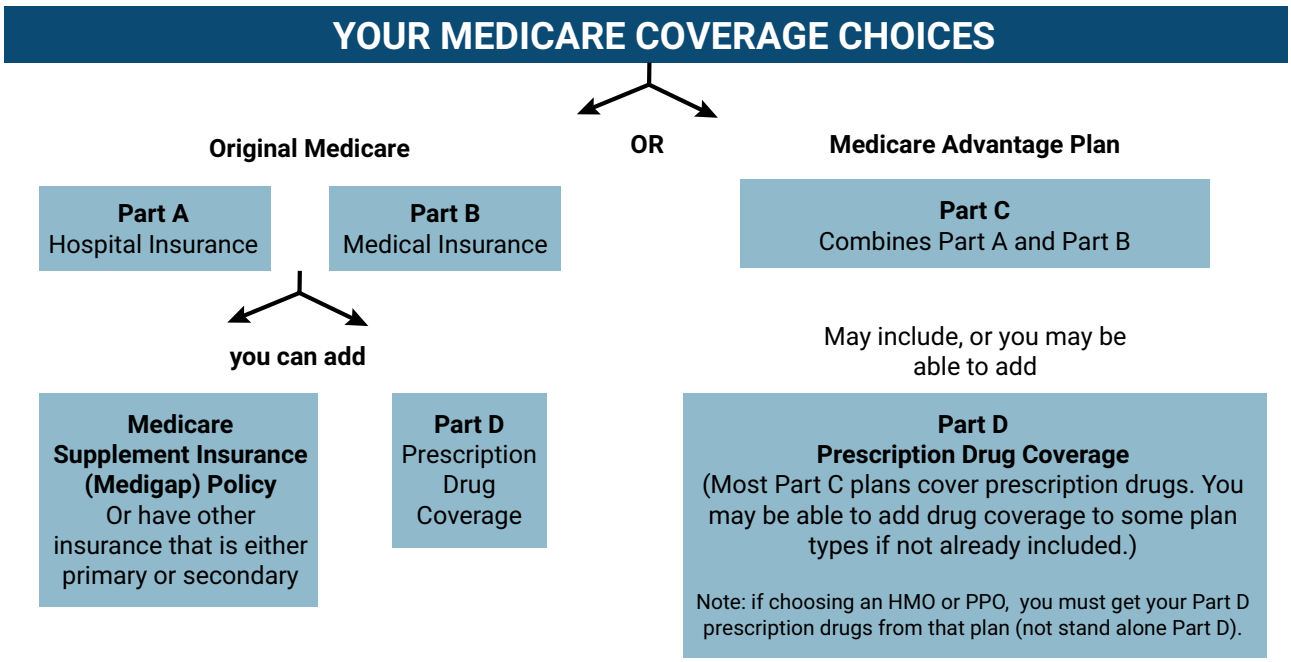


Figure B. Medicare covered services

	Part A Traditional Medicare	**Part B** Traditional Medicare	**Part D** Prescription Drug Plan	**Part C** Medicare Advantage
Inpatient hospital stays	✔			✔
Short-term rehabilitation *(inpatient or home health)*	✔			✔
Office and outpatient visits		✔		✔
Lab tests and imaging		✔		✔
Preventative care		✔		✔
Mental health treatment		✔		✔
Prescription drugs			✔	✔*
Dental				✔*
Fitness				✔*
Hearing				✔*
Vision				✔*
Other “supplemental benefits”				✔*

** = may be covered; depends on plan*

Figure C. Costs associated with Traditional Medicare (CY2022)

	Part A Original or Traditional Medicare	**Part B** Original or Traditional Medicare
Monthly premium	• Most people don't pay a monthly premium • If you paid into Social Security fewer than 30 quarters (7.5 years), you pay $499 / month	• $170.10 / month
Deductible and co-insurance	• $1,556 deductible for each "benefit period" • $389 coinsurance per day after 60 days • 20% cost for DME • Pay for private hospital room unless medically necessary • SNF days 21-100: $194.50 / day	• $233 deductible • 20% co-insurance for most services • Preventive services recognized by ACA have no cost sharing

Costs from https://www.medicare.gov/your-medicare-costs/medicare-costs-at-a-glance

Figure D. Select Medicare-covered behavioral health services

Medicare Part A covers mental health care in an inpatient setting.

- This can include a general hospital or a psychiatric hospital. Inpatient care received at a psychiatric hospital has a lifetime coverage limit of 190 days. Part A typically covers a beneficiary's room (not typically a private room), meals, nursing care (not private duty nursing), therapy and treatment, lab tests, and medications.

Medicare Part B covers mental health care on an outpatient basis in these types of settings:

- A health care provider's office
- A hospital outpatient department (possibly additional copayment or coinsurance)
- A community mental health center

And from these types of providers (as long as they accept Medicare "assignment"):

- Psychiatrist or another physician
- Clinical psychologist, social worker, or nurse specialist
- Nurse practitioner
- Physician assistant

Part B helps pay for these outpatient mental health services:

- One depression screening per year, done in a primary care provider's office or clinic to provide follow-up treatment and referrals.
- Individual and group psychotherapy by licensed professionals in the state where you get services.
- Family counseling, if the main purpose is to support your mental health treatment.
- Testing to assess whether or not you are getting the services you need and if they are helping you, including certain lab tests.
- Diagnostic tests
- Psychiatric evaluations
- Medication management
- Certain prescription drugs that aren't self-administered, like some injections
- Partial hospitalization. These are intensive outpatient services that you get during the day, but you don't have to stay overnight. This is instead of hospitalization.
- Your one-time "Welcome to Medicare" preventive visit that includes a review of your possible risk factors for depression.
- Your yearly "Wellness" visit when you talk with your health care provider about changes in your mental health.
- Medication, counseling, drug testing, and therapy services provided by opioid treatment programs
- One alcohol misuse screen per year for adults who use alcohol but don't meet the medical criteria for alcohol dependency

Part D (drug coverage) helps cover self-administered prescribed drugs.

Appendix D: External links

All links accessed November 2022.

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- https://www.law.cornell.edu/cfr/text/42/483.40
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