MEDICARE ADDICTION PARITY Project

Calendar Year (CY) 2024 Medicare Final Rules:
Physician Fee Schedule (PFS) and Outpatient Prospective Payment System (OPPS)
Substance Use Disorder and Mental Health Provisions

November 2023

The Centers for Medicare & Medicaid Services (CMS) released its Physician Fee Schedule (PFS) and Outpatient Prospective Payment System (OPPS) final rules for Calendar Year (CY) 2024 on November 2, 2023. Each year, CMS issues proposed regulations to make policy and technical changes to the Medicare program for the upcoming calendar year. The Legal Action Center (LAC) submitted PFS comments and OPPS comments to CMS supporting many proposals and recommending some additional expansions. The following charts summarize CMS's proposals relating to substance use disorder (SUD) and mental health (MH) coverage, LAC's comments, the final rules, and our next steps to continue to improve access to SUD treatment in Medicare.

CMS Proposal – PFS	LAC Comment	CMS Final Rule	Next Steps (if applicable)
General Behavioral Health Integration (BHI) Care Management: Revise the reimbursement rate for BHI services to more accurately value the work involved with the delivery of these services. Mental Health Counselors and Marriage and Family Therapists may also deliver these services.	LAC supported this proposal, and encouraged CMS to increase the rate even further and replicate these rate increases for SUD services that can be delivered in integrated care settings.	CMS finalized the rule as proposed, noting also that peers and addiction counselors may furnish these services "incident to" the billing by a Medicare-authorized physician, non-physician practitioner, or psychologist.	
Services Addressing Health-Related Social Needs: Establish separate coding and payment for community health workers (CHWs) and peer support specialists to deliver services to address social determinants of health (SDOH) – entitled community health integration	LAC supported this proposal, and encouraged CMS to add additional SUD and MH services that could be used as an initiating visit and additional SUD and	CMS finalized the rule with a modification to create additional PIN codes for beneficiaries with SUD and MH conditions that better reflect how peers deliver these services. CMS added more	Work with CMS to authorize other SUD and MH professionals – including clinical social workers, professional counselors, and marriage and family therapists – to

CMS Proposal – PFS	LAC Comment	CMS Final Rule	Next Steps (if applicable)
(CHI) and principal illness navigation (PIN) services – as well as a SDOH risk assessment. These services must be performed under the supervision of a provider who can bill evaluation and management (E/M) codes, following an E/M visit. The billing provider may partner with community-based organizations to deliver these services.	MH providers that could supervise these services.	initiating visits: the annual wellness visit (AWV) for both CHI and PIN, and psychiatric diagnostic evaluations and Health Behavior Assessment and Intervention (HBAI) for PIN, with a psychologist serving as the billing provider. CMS is also requiring patient consent for these services.	initiate and bill for these services when working with CHWs and peers. Ideally, CHWs and peers should also be able to initiate these services, as they often are an entry point into the health care system for people with SUDs and MH conditions.
Coverage of Marriage and Family Therapists (MFT) and Mental Health Counselors (MHC): Create new definitions for licensed and certified MFTs and MHCs and identify the services they can deliver to Medicare beneficiaries, which are any services that are furnished for the diagnosis and treatment of mental illness that they are legally authorized to furnish under state law. These practitioners must (1) have a Master's or Doctorate degree in counseling, (2) have performed 2 years or 3000 hours of supervised clinical experience post-degree, and (3) be licensed or certified in the state in which they furnish services. The definition of MHC includes professional counselors and addiction counselors who meet those criteria. These providers will be reimbursed at 80% of the lesser of the actual charge for the	LAC supported this proposal, and recommended CMS explicitly identify addiction counselors and alcohol and drug counselors in the regulations. LAC also requested CMS develop new codes that could be used by non-Master's level SUD counselors. While the reimbursement rate is statutory, LAC recommended CMS develop add-on codes that more appropriately value the work of these practitioners.	CMS finalized the rules as proposed at §§ 410.53 and 410.54, and reiterated that addiction counselors and alcohol and drug counselors who meet all the applicable educational, clinical supervised experience, and licensure requirements can enroll in Medicare as MHCs. CMS also clarified that individuals who meet these requirements, but are licensed under another title, can enroll in Medicare as MHCs. CMS stated that non-Master's level SUD counselors can still deliver care to Medicare beneficiaries under "incident to" billing, under the supervision of authorized providers.	Work with Congress to increase the reimbursement rate for clinical social workers (CSWs), MFTs, and MHCs to mirror those for non-physician medical providers. Work with Congress to enable CSWs, MFTs, and MHCs to bill for services delivered in SNFs. Work with CMS to allow for expanded billing of SUD counselor services delivered by non-Master's level SUD counselors when supervised by other practitioners.

CMS Proposal – PFS	LAC Comment	CMS Final Rule	Next Steps (if applicable)
services or 75% of the PFS rate for psychologists. They can deliver services via telehealth. Their services may not be separately billed in skilled nursing facilities (SNFs).			
Improving Mobile Crisis Care in Medicare: Create new codes describing psychotherapy for crisis services delivered outside of facilities and offices, reimbursed at 150% of the PFS rate for non-facility-based crisis psychotherapy services. Peers and other auxiliary personnel can assist in these services under "incident to" billing.	LAC supported this proposal.	CMS finalized the rule as proposed, while clarifying that they understand peers cannot perform psychotherapy and may consider other types of crisis care in future rule-making that is more comprehensive or team-based.	Work with Congress and CMS to secure coverage of more comprehensive and team-based crisis services, including those that meet the unique needs of individuals with SUD.
Health Behavior Assessment and Intervention (HBAI) Services: Allow HBAI services to be delivered and billed by CSWs, MFTs, and MHCs, not just by psychologists.	LAC supported this proposal.	CMS finalized the rule as proposed	
Adjustments to Payment for Timed Behavioral Health Services: Revise the reimbursement rate for psychotherapy services (CPT Codes 90832, 90834, 90837, 90839, 90840, 90845, 90846, 90847, 90849, 90853, GPFC1, GPFC2).	LAC supported this proposal and encouraged CMS to increase the reimbursement rate even further.	CMS finalized the rule, with a modification to increase the add-on psychotherapy codes billed with E/M visits (CPT Codes 90833, 90836, 90838) by the same rate.	Work with Congress to apply the Parity Act to Medicare to address discriminatory reimbursement rates. Work with Congress and CMS to continue to increase the reimbursement rates for psychotherapy, as well as

CMS Proposal – PFS	LAC Comment	CMS Final Rule	Next Steps (if applicable)
			other MH and SUD services that continue to be undervalued.
Updates to the Payment Rate for the PFS SUD Bundle (HCPCS G2086-G2088): Increase the current payment rate for office-based SUD bundled services to reflect the adjustment made to OTPs last year, as well as more psychotherapy per month.	LAC supported this proposal.	CMS finalized the rule as proposed.	
Rural Health Clinics and Federally Qualified Health Centers: Codify payment for MFTs and MHCs, cover intensive outpatient (IOP) services, allow MH and SUD services to be delivered under general supervision, authorize payment for CHI and PIN services, and increase the reimbursement rate for general care management services.	LAC supported these proposals.	CMS finalized the rule as proposed.	
Opioid Treatment Programs: Extend coverage of audio-only periodic assessments through the end of 2024.	LAC supported this proposal and recommended CMS extend this coverage permanently.	CMS finalized the rule as proposed at § 410.67(b). CMS will continue to review whether to allow audio-only periodic assessments permanently.	Continue advocacy with CMS and other agencies to secure permanent telehealth flexibilities for OTPs.
Comment Solicitation on Expanding Access to Behavioral Health Services: Requested comments on other policy	LAC recommended CMS:	CMS thanked commenters for their responses and may	Continue advocacy with Congress and CMS to achieve:

CMS Proposal – PFS	LAC Comment	CMS Final Rule	Next Steps (if applicable)
changes that could improve access to behavioral health services.	1. Provide guidance on using BHI to treat SUD. 2. Authorize coverage of IOP in additional settings. 3. Develop crosswalk codes to cover the full continuum of SUD treatment in community-based SUD facilities. 4. Continue to increase reimbursement rates for MH and SUD providers. 5. Use the terms “mental health” and “substance use disorder” rather than “behavioral health.” 6. Remove the overbroad custody exclusion in Medicare. 7. Remove administrative billing barriers for beneficiaries who are dually eligible in Medicare and Medicaid. 8. Urge Congress to apply the Mental Health Parity and Addiction Equity Act to Medicare.	consider them in future rulemaking.	1. Greater integrated care for SUDs. 2. Coverage of IOP in more SUD treatment settings. 3. Coverage of the full continuum of SUD care in community-based SUD treatment facilities. 4. Higher and more equitable reimbursement rates for MH and SUD providers. 5. More precise language on MH and SUD benefits. 6. Ensure individuals on bail and parole can enroll in Medicare. 7. Streamlined process for non-authorized Medicare providers to get denials from Medicare to bill Medicaid to serve dual eligible individuals. 8. Achieve full parity by applying the Mental Health Parity and Addiction Equity Act to all parts of Medicare.

In the OPPS rule, CMS established regulations governing the coverage of intensive outpatient (IOP) services in Medicare, for which LAC advocated and helped pass in the Consolidated Appropriations Act of 2023. LAC participated in in discussions about the structure of this new benefit with CMS and identified ways to ensure it could be meaningfully available to beneficiaries with SUD.

CMS Proposal – OPPS	LAC Comment	CMS Final Rule	Next Steps (if applicable)
IOP Scope of Benefits: Add regulations to define IOP and set out the conditions and exclusions for coverage. The definition of IOP is consistent with that for partial hospitalization (PHP) services, with the exception that IOP is not required to be in lieu of inpatient hospitalization and is for those who need 9 or more hours of care per week, rather than a minimum of 20 hours. CMS stated that these benefits are available to patients with SUDs, not just those with MH conditions. Excluded IOP from the outpatient MH treatment limitation.	LAC supported this proposal, and encouraged CMS to clarify in the regulations that these benefits are available to beneficiaries with SUDs and that SUD providers may deliver these services.	CMS finalized the rule largely as proposed at §§ 410.43, 410.44, and § 410.155(b)(2)(iii) with amendments to both the IOP and PHP regulations to clarify that beneficiaries may have a "mental health **or substance use disorder** diagnosis," and that services may be delivered by "mental health **or substance use disorder** professionals."	Work with CMS to revise the patient eligibility criteria to remove requirements that fail to align with the American Society of Addiction Medicine (ASAM) Criteria for Level 2.1 (IOP) and perpetuate stigma by requiring patients to have an adequate support system outside the program and not be judged to be a danger to themselves or others.
IOP Certification and Plan of Care Requirements: Codify the requirements for IOP, mirroring those for PHP, except that a physician must certify that the beneficiary requires a minimum of 9 hours of services per week for IOP and 20 hours of services per week for PHP, with recertification occurring no less frequently than every 60 days.	LAC recommended that non-physician practitioners be authorized to certify the need for IOP and PHP and develop the treatment plan. LAC also recommended that CMS codify a standard 60-day interval for recertification, rather than "no less frequently."	CMS finalized the rule as proposed at § 424.24(d).	Work with Congress to allow non-physician practitioners to certify the need for IOP and PHP and develop the treatment plan. Work with CMS to ensure that Part C plans and regional contractors do not require recertification more frequently than every 60 days.

CMS Proposal – OPPS	LAC Comment	CMS Final Rule	Next Steps (if applicable)
Coding and Billing for PHP and IOP Services: Establish a standard set of services that would be used for both IOP and PHP, including some changes to the existing list – such as adding group psychotherapy, multiple family group psychotherapy, HBAI, and adaptive behavior treatment – and requesting comments on other additions. Future changes relating to coding for services already enumerated in the regulations may be made to this list through a sub-regulatory process.	LAC supported this proposal and encouraged CMS to include CHI and PIN services, caregiver services, and case management and care coordination services. LAC also encouraged CMS to include more SUD-specific services including SUD screening and diagnostic evaluations, individual and group SUD counseling, psychoeducation, medication management, and withdrawal management.	CMS finalized the rule, with the addition of PIN and caregiver services. CMS also added additional crisis psychotherapy services.	Work with CMS to ensure IOP and PHP services align with the ASAM Criteria for Levels 2.1 (IOP) and 2.5 (PHP).
Proposed Payment Rate Methodology for PHP and IOP: Establish per diem rates for each setting of care for 3-service days and 4-service days that would be used for both PHP and IOP. At least one service must be from a separate list of primary services. Providers would be reimbursed at the 3-service day rate even when a beneficiary receives fewer services in a day.	LAC supported this proposal.	CMS finalized the rule as proposed.	

CMS Proposal – OPPS	LAC Comment	CMS Final Rule	Next Steps (if applicable)
Coverage of IOP Services in Community Mental Health Centers (CMHC), Rural Health Clinics (RHC), and Federally Qualified Health Centers (FQHC): Codify comparable IOP requirements as those for hospital outpatient departments.	LAC supported this proposal, but expressed concern with CMS's proposal to limit coverage of IOP and other MH services on the same day in RHCs and FQHCs.	CMS finalized the rule as proposed, but clarified that IOP and other MH services may be furnished on the same day but the MH services are considered packaged with the RHC and FQHC IOP rates.	
Coverage of IOP Services Furnished by Opioid Treatment Programs (OTP): Develop a weekly payment rate add-on code for OTPs to deliver IOP services to Medicare beneficiaries with an opioid use disorder (OUD), with consistent definitions and requirements as for those in other settings, but with a reduction in payment for services that are duplicative of those already being delivered in the OTP weekly bundled rate (OUD medications and toxicology testing). Beneficiaries pay no copayment for OTP IOP services, similar to the previously established OTP services. OTPs would need to attest that the beneficiary needs at least 9 hours of IOP services per week, and that at least 9 services were delivered (though they do not need to be 9 hours).	LAC supported this proposal, but recommended that services be reimbursed at a per diem rate. LAC recommended CMS not deduct the individual and group counseling from the IOP payment amount. LAC also recommended the first recertification occur on the 60th day, consistent with other settings for IOP, rather than the 30th day as proposed.	CMS finalized the rule largely as proposed at § 410.67(b), with several modifications: (1) include individual and group counseling in the OTP IOP payment rate, (2) require recertification no less frequently than every 60 days, and (3) allow non-physician practitioners to provide the required certification and plan of care. CMS clarified that the eligibility criteria for other settings (an adequate support system outside of treatment) do not apply to OTPs. CMS also clarified that it does not have the authority to cover OTP services for other SUDs or for MH conditions.	Work with Congress and CMS to allow OTPs to deliver services to beneficiaries with other SUDs and MH conditions. Work with Congress and CMS to authorize coverage of IOP in other settings that treat patients with SUD, including community-based SUD treatment facilities.