MEDICARE ADDICTION PARITY Project

Calendar Year (CY) 2025 Medicare Final Rules:
Physician Fee Schedule (PFS) and Outpatient Prospective Payment System (OPPS)
Substance Use Disorder and Mental Health Provisions

November 2024

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) 2025 on November 1, 2024. 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.

Physician Fee Schedule (PFS) Final Rule

CMS Proposal – PFS	LAC Comment	CMS Final Rule	Next Steps (if applicable)
Audio-Only Telehealth: CMS proposed to permanently revise its regulations to state that telehealth may include two-way, real-time audio-only technology if the provider is technically capable of using audio-visual communication and the patient is not capable of or does not consent to use video technology.	LAC supported this proposal.	CMS finalized the rule as proposed at 42 C.F.R. § 410.78(a)(3).	Continue to advocate to Congress and CMS to expand access to audio-only telehealth while preserving access to in-person care and patient choice in service delivery.
Increased Reimbursement Rates for SUD & MH Screening: CMS proposed to increase the work relative value unit (RVU) of annual alcohol misuse screening, brief face-to-face behavioral health counseling for alcohol misuse, and annual depression screening.	LAC supported this proposal, encouraging CMS to use recent data to determine appropriate payments for all MH & SUD services and to monitor access.	CMS finalized these rate increases as proposed for HCPCS codes G0442, G0443, and G0444.	Continue to advocate to Congress and CMS to improve reimbursement rates for MH and SUD services and providers.

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Safety Planning Interventions (SPI) and Post-Discharge Telephonic Follow-Up Contact Interventions (FCI): CMS proposed new codes and payment for SPI and FCI to support patients with a suicidal or overdose crisis. SPI was proposed as a 20-minute add-on code to be billed with an evaluation and management (E/M) visit or psychotherapy. FCI was proposed as a monthly bundled payment, for which at least one successful telephonic contact with the beneficiary must be made.	LAC supported these proposals, and recommended CMS amend the SPI description to explicitly include SUD and enable this code to be billable as a standalone service, rather than an add-on. LAC also requested these services be able to be performed by auxiliary personnel, such as peers, incident to the billing practitioner.	CMS adopted the new codes (SPI: G0560; FCI: G0544) and payment, and adopted LAC's recommendations for the description of SPI to include SUD and to bill this code as a standalone service. CMS also added SPI as a telehealth service. SPI may only be performed by the billing practitioner, not auxiliary personnel, but CMS said it will continue to consider this issue for future rulemaking. FCI may be performed by auxiliary personnel incident to the billing practitioner.	Advocate to CMS for SPI to be billable by auxiliary personnel – such as peers – incident to the billing practitioner.
Digital MH Treatment (DMHT): CMS proposed Medicare payment to billing practitioners for DMHT devices furnished incident to or integral to professional behavioral health services used in conjunction with ongoing behavioral health treatment or under a behavioral health treatment plan of care. Covered devices must be cleared by the FDA.	LAC recommended CMS require any DMHT to demonstrate compliance with federal health privacy laws, including HIPAA and 42 U.S.C. Part 2, and applicable state MH & SUD privacy requirements. LAC also recommended CMS ensure that DMHT does not further perpetuate existing health care biases.	CMS finalized these codes (HCPCS G0552, G0553 and G0554). CMS acknowledged privacy concerns, but stated that there are cybersecurity requirements as part of the FDA review process.	Continue to advocate to Congress, CMS, and the FDA for stronger privacy and confidentiality protections for DMHT. Continue to advocate for health equity in the use of DMHT and any other health care services or supplies.

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Rural Health Clinics (RHC) & Federally Qualified Health Centers (FQHC): CMS proposed authorizing RHCs and FQHCs to bill the individual codes that make up general care management, to delay the in-person requirement for telehealth MH services, and to provide an intensive outpatient program (IOP) payment rate for 4+ services per day at the hospital outpatient department rate. CMS also proposed updating the Conditions for Certification and Conditions for Coverage to no longer require more than 50% of services delivered to be primary care services to enable RHCs greater flexibility to provide more specialty services including MH and SUD services.	LAC supported these proposals.	CMS finalized these rules as proposed. CMS also withdrew a proposal to codify the statutory requirement that RHCs and FQHCs cannot be a rehabilitation facility or a facility primarily for the care and treatment of mental diseases, as commenters expressed concerns that this would lead to greater confusion and barriers to MH and SUD services.	
Opioid Treatment Programs (OTPs): CMS proposed permanently authorizing audio-only telehealth for periodic assessments and audio-visual telehealth for the initiation of methadone. CMS also proposed updating the payment rate for intake activities to incorporate the social determinants of health (SDOH) risk assessment. CMS requested comments on payment to OTPs for coordinated referrals to community-based organizations that address unmet health-related social needs, provide	LAC supported these proposals, and encouraged CMS to continue to expand access to services addressing social determinants of health, harm reduction services, and recovery support services both in and outside of OTPs.	CMS finalized the telehealth flexibilities at § 410.67(b). CMS also clarified that, consistent with SAMHSA regulations, methadone may be prescribed via audio-only telehealth if the patient is in the presence of a licensed practitioner who is registered to prescribe and dispense controlled medications and when audio-visual telehealth is not available or not feasible.	Continue to advocate to Congress and the DEA to ensure the greatest possible access to medications for opioid use disorder, including through telehealth. Advocate for additional coverage and reimbursement of harm reduction services for patients in other settings.

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harm reduction services, and/or provide recovery support services.		CMS finalized adding the SDOH risk assessment to the intake activities as well as periodic assessments, and clarified that it may be performed by appropriately licensed or credentialed personnel and would include assessing the patient's need for harm reduction interventions and recovery support services. CMS created a new code for coordinate care and/or referral services (G0534), a new code for patient navigational services (G0535), and a new code for peer recovery support services (G0536). CMS also established new codes to cover the new FDA-approved medications for opioid use disorder.	
Request for Information (RFI) on Services Addressing Health-Related Social Needs: CMS requested comments on Community Health Integration (CHI), Principal Illness Navigation (PIN, PIN-PS), and the Social Determinants of Health Risk Assessment to consider for future rulemaking.	LAC recommended these services be deliverable and billable as standalone codes.	CMS clarified that these services may be furnished by clinical social workers. CMS thanked commenters for their other feedback and will consider this information for future rulemaking.	Continue to advocate to CMS for these services to be deliverable and billable as standalone codes to more effectively meet the needs of beneficiaries.

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RFI on Payment for MH & SUD Services Furnished in Additional Settings: CMS requested comments on freestanding SUD treatment facilities, crisis stabilization units, urgent care centers, and certified community behavioral health clinics (CCBHCs).	LAC provided comments on ways to appropriately cover IOP and other SUD services in freestanding SUD treatment facilities, and further urged CMS to increase access to MH & SUD care in the other discussed settings.	CMS thanked commenters for their feedback and may consider this input for potential policy proposals through future rulemaking.	Continue to advocate to Congress and CMS to authorize coverage of freestanding SUD treatment facilities for the full continuum of SUD care, as well as other settings that deliver MH and SUD services.

Outpatient Prospective Payment System (OPPS) Final Rule

LAC first identified Medicare's overbroad "custody" exclusion in our Landscape Review in February 2021, in which we highlighted how the lack of Medicare coverage for people living in the community on supervised release, compounded by the late enrollment penalties imposed on those released from incarceration for missing their enrollment window, were a significant burden on older adults and people with disabilities in need of SUD treatment. We identified this issue as one of our top priorities in our October 2021 Roadmap for Reform, and have urged CMS and Congress to resolve this unnecessary barrier to care.

Congress created a Special Enrollment Period (SEP) for Medicare for exceptional circumstances in the Consolidated Appropriations Act of 2021, which CMS used to establish an SEP for formerly incarcerated individuals as a result of LAC's advocacy, along with many of our partner organizations including Justice in Aging and the Medicare Rights Center. While this SEP enabled people to enroll in Medicare upon their release from custody and removed the financial penalties for those enrolling, it reinforced the overbroad definition of custody, which created additional confusion and barriers when implemented in January 2023.

In January 2024, LAC partnered with Justice in Aging and the Medicare Rights Center to send a sign-on letter to CMS urging the agency to amend its definition of custody so people released from incarceration and living in the community under supervised release could access Medicare coverage. We worked closely with stakeholders and CMS leadership to identify the barriers and address concerns. As a result, CMS proposed narrowing its definition of custody in the CY25 OPPS. In addition to our organizational comments, LAC, Justice in Aging, and Medicare Rights Center led another sign-on letter commenting in support of CMS's proposal, with 117 signatories. We are tremendously grateful to our partners and to CMS for this historic change that will greatly improve access to care for people with a history of involvement in the criminal legal system.

CMS Proposal – OPPS	LAC Comment	CMS Final Rule	Next Steps (if applicable)
Custody Exclusion: CMS proposed narrowing its definition of custody so formerly incarcerated individuals on supervised release – those on bail, parole, probation, and home detention – could access Medicare without needing to rebut the presumption that a third party (such as the penal authority or a local government) is paying for care. It proposed adopting Medicaid's approach to coverage of services for individuals residing in halfway houses, which would have been limited to a set of circumstances based on whether they have freedom of movement. CMS also proposed aligning the SEP for formerly incarcerated individuals to be consistent with this updated definition. When individuals enroll in Medicare using the SEP, they can select a retroactive date to the first day of the month of their release from incarceration (up to 6 months).	LAC supported this proposal, and recommended CMS add an explicit statement about who is eligible for Medicare services, and remove people "under arrest" from the list of those who are still considered to be in "custody." LAC further recommended CMS provide equitable relief for people using the SEP prior to the 1/1/25 effective date, and to provide outreach and education to the community to help with enrollment.	CMS finalized the rule at § 411.4(b), adopting LAC's recommendations to add an illustrative list describing who is eligible, and to remove people under arrest from the exclusion. Instead of the term "bail," CMS used the broader term "released to the community pending trial." CMS also went further than Medicaid to cover all people residing in halfway houses (or other community-based transitional facilities). The circumstances that continue to be considered in "custody," such as on medical furlough, can still be rebutted (and thus covered under Medicare) if there is no legal obligation for a third party to pay. CMS finalized the SEP provisions at §§ 406.27(d), 407.23(d). While unable to provide equitable relief, CMS encouraged individuals to contact the Social Security Administration (SSA) if they were released between 1/1/23 and 1/1/25.	Help educate the community about this important change and ensure people can access the coverage they need! Advocate to CMS to conform Medicaid's inmate exclusion rule with respect to halfway houses with Medicare's new definition of custody.

CMS Proposal – OPPS	LAC Comment	CMS Final Rule	Next Steps (if applicable)
IOP and PHP Reimbursement Rates: CMS proposed updated payment rates for IOP and PHP, which maintain the 3-service day and 4-service day per diem rates, separate for hospital-based IOPs and CMHCs.	LAC supported this proposal, but encouraged CMS to increase the CMHC rate to align with the hospital-based rate, and to ensure these updated rates are reflected in the OTP add-on code.	CMS finalized the rates for IOP and PHP as proposed.	
MEDICAID – Continuous Eligibility for Children: CMS proposed updating the Medicaid regulations to conform to the Consolidated Appropriations Act of 2023, enabling 12-month continuous eligibility for youth up to age 19 in Medicaid and CHIP. CMS also proposed removing nonpayment of premiums as an optional exception to continuous eligibility in CHIP.	LAC supported this proposal.	CMS finalized the rule as proposed at §§ 435.926, 457.342.	
MEDICAID – Exceptions to the Four Walls Clinic Requirement: CMS proposed adding new exceptions that would allow clinics to deliver services to Medicaid enrollees outside of the "four walls" of the clinic: services furnished by Indian Health Service/Tribal clinics, as a mandatory exception; clinics that are primarily organized for the care and treatment of outpatients with MH and	LAC supported this proposal, and encouraged CMS to make the exception for clinics primarily organized for MH and SUD outpatient treatment mandatory for states.	CMS finalized the rule as proposed at § 440.90.	

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SUD, as an option for states; and clinics located in a rural area, as an option for states.			
Hospital Conditions of Participation (CoP) for Maternal Health: CMS proposed new CoPs for hospitals and critical access hospitals (CAHs) related to obstetrical care. These included proposed standards for organization, staffing, and delivery; training requirements; standards for quality assessment and performance improvement (QAPI); standards for emergency services readiness; and policies and procedures for transferring patients.	LAC supported these proposals, and encouraged CMS to expand them to include (1) standards for the identification, treatment, and follow-up care of patients who present with a SUD-related condition; (2) trainings that include SUD-related topics; (3) informed consent and patient privacy protection policies; and (4) quality metrics related to MH and SUD in the QAPI program, with public reporting.	CMS finalized the rules, largely as proposed, at §§ 482.21, 482.43, 482.59, 482.55, 485.618, 485.641, 485.649. There will be a phase-in approach to implementation over a 2-year period. CMS also provided, in the preamble, additional resources related to culturally and linguistically appropriate care as well as MH and SUD care for pregnant, perinatal, and postpartum individuals.	Advocate to CMS to strengthen hospital CoPs for pregnant and postpartum individuals with SUDs, as well as all individuals who present to the hospital or emergency department with a SUD-related condition, to ensure they get the appropriate care and treatment they need.