Overview of the 2024 Physician Fee Schedule and Hospital Outpatient Prospective Payment System Final Rules

Nov. 7, 2023

The following provides a high-level overview of mental health and substance use disorder care provisions included in final rules for both the 2024 Medicare Physician Fee Schedule and the Hospital Outpatient Prospective Payment System. The OPPS summary begins on **p. 8** of this document.

Summary of 2024 Physician Fee Schedule Final Rule (CMS-1784-F)

The Centers for Medicare and Medicaid Services (CMS) recently issued its final rule for Calendar Year (CY) 2024 Physician Fee Schedule (PFS), scheduled to be officially published in the Federal Register on Nov. 16, 2023. The CY 2024 PFS establishes policy changes for Medicare payments and related policies effective on or after Jan. 1, 2024. National Council for Mental Wellbeing (National Council) submitted comment in September 2023 in response to the proposed rule.

Adjustment Factor and Estimated Impact

Overall, payment rates under the PFS will be reduced by 1.25% compared to CY 2023, and the final CY 2024 PFS conversion factor is $32.74, a decrease of 3.4% from CY 2023. This overall impact reflects provisions in the Consolidated Appropriations Act, 2023 (CAA, 2023) as well as statutory budget neutrality requirements. See Table 116: Calculation of the CY 2024 PFS Conversion Factor for more information.

Given the budget neutrality requirements and finalized policies in this rule on PFS services, estimated impact on total allowed charges of all the finalized changes varies by specialty. For more information, see Table 118: CY 2024 PFS Estimated Impact on Total Allowed Charges by Specialty in the final rule.

New Policies Advancing Access to Behavioral Health Services

Inclusion of Marriage and Family Therapists and Mental Health Counselors as Medicare Providers

Consistent with CAA, 2023, CMS is finalizing two new regulation sections at §410.53 and §410.54 to codify the respective coverage provisions for marriage and family therapists (MFTs) and mental health counselors (MHCs), as well as addiction counselors who meet MHC requirements, to now enroll in Medicare and bill for services furnished starting Jan. 1, 2024. MFTs and MHCs are also added as distant-site practitioners for purposes of furnishing telehealth services and included as eligible for payment for

services furnished at rural health clinics (RHCs) and federally qualified health centers (FQHCs). CMS has also codified the payment amount for clinical social worker (CSW), MFT, and MHC services, which is 80% of the lesser of the actual charges for the services or 75% of the amount determined for clinical psychologist (CP) services under the PFS. Additionally, CAA, 2023 excludes MFT and MHC services from consolidated billing requirements under the SNF prospective payment system. (See separate SNF rule for more details.) Enrollment requirements for these new provider types provide that the practitioner:

- Possesses a master's or doctor's degree that qualifies for licensure or certification as a marriage and family therapist or counselor pursuant to state law of the state in which such individual furnishes the services defined as marriage and family therapist or mental health counselor services respectively.
- After obtaining such degree, has performed at least two years or 3,000 hours of post-master's-degree clinical supervised experience in marriage and family therapy or mental health counseling in an appropriate setting such as a hospital, SNF, private practice or clinic.
- Is licensed or certified as an MFT or as an MHC, clinical professional counselor or professional counselor by the state in which the services are performed.

MFT and MHC Enrollment Provisions: Under §424.510, a provider or supplier must complete, sign and submit to its assigned Medicare Administrative Contractor the appropriate Form CMS-855 (OMB Control No. 0938-0685) application in order to enroll in the Medicare program and obtain Medicare billing privileges. CMS is finalizing that the MFT and MHC supplier types, like most nonphysician practitioner types, be subject to limited-risk screening under §424.518. Individuals who meet the MFT or MHC requirements would enroll in Medicare via the Form CMS-855I application (Medicare Enrollment Application — Physicians and Non-Physician Practitioners; OMB No. 0938-1355) and can begin submitting their enrollment applications after the publication of the CY 2024 PFS final rule, with services payable under Medicare Part B beginning Jan. 1, 2024. Consistent with the CAA 2023, CMS is making conforming change to §405.400, which defines "practitioner" for opt-out purposes, to include MFTs and MHCs in the definition of practitioner. This is consistent with other practitioners listed in the regulation text as authorized to furnish services for the diagnosis and treatment of mental illnesses, such as clinical psychologists and clinical social workers.

MFT and MHC Clinical Hour Clarification: In response to comments seeking clarification on clinical hour provisions, CMS will defer to state law regarding specifics on how many direct contact hours must be direct client contact, as well as for the term "clinical supervised experience," and requirements regarding the nature of the two years or 3,000 hours of clinical supervised experience. CMS also reiterated that clinical supervised experience would need to have occurred after obtaining the qualified applicable degree pursuant to state law consistent with sections 1861(lll)(2) and1861(lll)(4) of the Act.

MFT and MHC Terminology Variation Clarification: CMS also noted variation in the terminology used for licensure across states for MHCs and MFTs and sought information pertaining to other types of professionals who may meet the applicable requirements for enrollment as mental health counselors. In response to the comments on this issue, CMS clarified that individuals who meet all of the applicable statutory and regulatory qualifications for education and clinical supervised experience for the MHC

benefit category, but who are licensed or certified by their state to furnish mental health counseling under a different title, are eligible to enroll in Medicare under the Part B "mental health counselor" statutory benefit category.

HCPCS Codes for MFTs and MHCs: Regarding specific coding with these new provider types, CMS noted that most HCPCS codes do not specify practitioners in the code descriptor, and thus no change is required for most codes describing services for the diagnosis and treatment of mental illness that MFTs and MHC are legally able to furnish under state law. However, CMS finalized a revision to the code descriptor for HCPCS code G0323 to allow MFTs, MHCs, CPs and CSWs to bill for monthly Behavioral Health Integration services. Furthermore, CMS is increasing payment for general behavioral health integration services for both CPT code 99484 and HCPCS code G0323 by increasing the work RVU to 0.93 from the current 0.61 and increasing the work time to 21 minutes, to match the results of the surveyed work time, with direct PE inputs as recommended by the RUC without refinement. CMS noted that they continue to believe that there is a systemic undervaluation of work estimates for behavioral health services and therefore had proposed values for CY 2024 that they believe will more accurately value the work involved in delivering behavioral health services.

MFT and MHC Services Furnished at FQHCs and RHCs: CMS is codifying payment provisions for MFTs and MHCs at RHCs and FQHCs beginning Jan. 1, 2024, to be paid under the RHC AIR and FQHC PPS, respectively. As eligible RHC and FQHC practitioners, MFTs and MHCs would follow the same policies and supervision requirements as a PA, NP, CNM, CP and CSW. Also consistent with CAA, 2023, CMS is implementing conforming changes to Certification or Coverage (CfCs) to include MFT and MHC services as recognized staff for RHCs and FQHCs, by finalizing the addition of MFT and MHC to the list of practitioners who may be the owner, employee, or furnish services under contract to the clinic or center. Finally, regarding updates to supervision requirements for behavioral health services furnished at RHCs and FQHCs, CMS is finalizing the proposal to reflect that behavioral health services can be furnished under general supervision of the physician (or other practitioner) when these services or supplies are provided by auxiliary personnel incident to the services of a physician (or another practitioner).

Hospice Interdisciplinary Group (IDG): Notably, regarding hospice programs, CMS' final rule specifies that the IDG must include, at minimum, an SW, an MFT or an MHC. In the final rule, CMS removed "depending on the preferences and needs of the patient" to provide additional flexibility for hospice programs to choose the members of the IDG. CMS clarified that it would be within the individual hospice's purview to allow for the MFT or MHC to accompany the nurse during the initial assessment. CMS also clarified that the IDG will only be required to include one SW, one MFT or one MHC and that the hospice program is not required to include all three provider types in the IDG, though they may choose more than one of these professions to serve as members. Further, CMS stresses that hospice programs may choose to have non-IDG staff that provide care to the patient attend the IDG meetings to share patient status, concerns and recommendations.

Terminology: CMS noted that, in past rulemaking, they have considered the term "mental health" to be inclusive of diagnosis and treatment of substance use disorders. National Council provided comment

that the terminology used should be more explicitly inclusive and clear regarding mental health and substance use disorders.

New Codes for Psychotherapy for Crisis Services

Consistent with CAA, 2023, CMS is establishing two new HCPCS codes — G0017 and G0018 — for psychotherapy for crisis services that are furnished in an applicable site of service, other than the office setting, at which the non-facility rate for psychotherapy for crisis services applies. The payment amount for these psychotherapy for crisis services is equal to 150% of the fee schedule amount for non-facility sites of service for HCPCS codes 90839 and 90840 respectively. CMS recognized comments requesting CMS consider payment for crisis care that is more comprehensive or team-based; they agreed with commenters on the importance of this issue and reported that they may consider feedback for future rulemaking.

Health Behavior Assessment and Intervention (HBAI) Services

CMS finalized the proposal to allow HBAI services (described by CPT codes 96156, 96158, 96159, 96164, 96165, 96167 and 96168) to be billed by CSWs, MFTs and MHCs, in addition to clinical psychologists, to provide for better integration of physical and behavioral health care.

Adjustments to Payment for Timed Behavioral Health Services

CMS is finalizing the 19.1% increase to the work RVUs for the standalone psychotherapy codes, transitioned over the course of four years, as proposed. National Council provided comment regarding the need for consistency across the family of psychotherapy codes. In response to commenters, CMS will also apply the same increase to the work RVUs for the psychotherapy codes that are billed as an add-on to an E/M visit (CPT codes 90833, 90836 and 90838), as CMS agrees that the work involved in furnishing the psychotherapy add-on CPT codes is very similar to the work of furnishing the standalone psychotherapy CPT codes. CMS therefore agrees that it is appropriate to apply the increase to the psychotherapy codes billed as an add-on to an E/M visit, in addition to the standalone psychotherapy codes. CMS is also finalizing the proposed increase to the work RVUs of the codes describing HBAI services (CPT codes 96156, 96158, 96159, 96164, 96165, 96167 and 96168), as these codes are similar to the psychotherapy services, in that these codes are also timed services and are generally provided person-to-person without support from clinical staff.

Updates to the Payment Rate for the PFS Substance Use Disorder (SUD) Bundle and Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

In the CY 2023 PFS, CMS finalized a modification to the payment rate for the non-drug component of the bundled payment for episodes of care under the Opioid Treatment Program (OTP) benefit, to base the rate for individual therapy on a crosswalk to CPT code 90834 (“Psychotherapy, 45 minutes with patient”) instead of the CPT code relating to a 30-minute psychotherapy session. CMS is finalizing, as proposed, an increased payment rate for HCPCS codes G2086 (“Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy

and counseling; at least 70 minutes in the first calendar month") and G2087 ("Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month") to reflect two individual psychotherapy sessions per month, based on a crosswalk to the work RVUs assigned to CPT code 90834, rather than CPT code 90832 ("Psychotherapy, 30 minutes with patient").

For CY 2024, CMS also proposed several modifications to the policies governing Medicare coverage and payment for OUD treatment services furnished by OTPs. To better align coverage for periodic assessments furnished by OTPs with the telehealth flexibilities described in section 4113 of the CAA 2023, CMS is finalizing the proposal to extend the audio-only flexibilities for periodic assessments furnished by OTPs when video is not available through the end of CY 2024, to the extent that use of audio-only communications technology is permitted under the applicable SAMHSA and DEA requirements at the time the service is furnished, and all other applicable requirements are met. CMS will continue to evaluate this issue, including reviewing relevant SAMHSA and DEA guidance, and may consider additional changes through future rulemaking.

Behavioral Health-specific Updates to the Quality Payment Program (QPP):

CMS is finalizing, as proposed, five new MVPs, two of which are Women's Health and Mental Health and Substance Use Disorder. CMS is also finalizing the proposal to add five new episode-based measures to the cost performance category, which includes Depression as well as Psychoses and Related Conditions, beginning in the CY 2024 performance period/2026 MIPS payment year. Appendix 3: MVP Inventory of the final rule provides further discussion of each new MVP. More information on the final rule regarding QPP policy overview is provided on this fact sheet.

After consideration of public comments, CMS is finalizing the proposal to add §414.1365(e)(4)(i), which states that, for subgroups, beginning with the CY 2023 performance period/2025 MIPS payment year, the affiliated group's complex patient bonus will be added to the final score. CMS noted that it will consider commenters' recommendation to assign the higher of the affiliated group's or subgroup's complex patient bonus score when CMS can calculate the complex patient bonus score at the subgroup level.

Comment Solicitation on Expanding Access to Behavioral Health Services

CMS expressed appreciation for the many detailed comments received and noted that they may consider this input for potential policy proposals through future rulemaking. In the final rule, CMS acknowledged comment regarding the importance of including Certified Community Behavioral Health Centers (CCBHCs) as a Medicare provider type in advancing efforts to improve access to behavioral health services for beneficiaries: "Some commenters requested that CMS consider the inclusion of [CCBHCs] in the Medicare program, which they stated would offer incredible value to beneficiaries. While CCBHCs are not a specific provider type in Medicare, CCBHCs are required to establish care coordination with entities such as with FQHCs and RHCs. Given this preexisting relationship, the overlap for MFT and MHC services that could be furnished in either location, and because behavioral health services are optional at FQHCs, advancing a relationship and partnership through these entities in the Medicare program could be a point for CMS' further exploration as efforts to improve behavioral health

care for beneficiaries advance." CMS responded that new provider types must be authorized by statute, and National Council looks forward to legislative efforts to this end.

New Provisions Regarding Services Addressing Health-Related Social Needs and Caregiver Training

Social Determinants of Health Risk Assessment

CMS is finalizing the proposal to add elements to the Annual Wellness Visit (AWV) by adding a new Social Determinants of Health (SDOH) risk assessment as an optional, additional element of the AWV, with an additional payment proposed to be paid at 100% of the fee schedule amount of the risk assessment. The new SDOH risk assessment will be payable separately, with no beneficiary cost sharing (when provided with the AWV). CMS clarified in the final rule that clinicians identified in the definition of "Health Professional" (42 CFR 410.15[a]) as eligible to furnish the AWV would also be eligible to furnish the SDOH risk assessment as an additional element of the AWV.

CMS is also finalizing a new stand-alone G code, now assigned as HCPCS code G0136, "Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months." CMS received many comments related to the proposed requirement that SDOH risk assessment be furnished the same date as an E/M visit, and some commenters requested that clinical psychologists be allowed to furnish SDOH risk assessment and specified that the SDOH risk assessment should be billable with CPT code 90791 and HBAI codes in addition to E/M visits. Regarding the types of associated visits that can be performed with HCPCS code G0136, CMS' aim is to allow behavioral health practitioners to furnish the SDOH risk assessment in conjunction with the behavioral health office visits they use to diagnose and treat mental illness and substance use disorders. CMS is finalizing that, in addition to an outpatient E/M visit (other than a Level 1 visit by clinical staff) as proposed, SDOH risk assessment can also be furnished with CPT code 90791 ("Psychiatric diagnostic evaluation") and the HBAI services. Additionally, CMS is finalizing that HCPCS code G0136 may also be performed in conjunction with an AWV. CMS is not finalizing the requirement that the SDOH risk assessment be performed on the same date as the associated E/M or behavioral health visit (such as CPT code 90791 or HBAI codes), for the operational ease of practitioners.

Community Heath Integration (CHI) and Principal Illness Navigation (PIN) Services

For CY 2024, CMS is finalizing coding and separate payment for CHI and PIN services that account for the involvement of important health care support staff, such as community health workers, care navigators and peer support specialists.

CMS is also finalizing the proposed inclusion of CHI and PIN services in the general care management HCPCS code G0511 when these services are provided by RHCs and FQHCs, clarifying that RHCs and FQHCs may bill HCPCS code G0511 multiple times in a calendar month as long as all of the requirements for each service are met.

Caregiver Training Services (CTS)

For CY 2024, CMS is finalizing the proposal to make payment when practitioners train caregivers to support patients with certain diseases or illnesses in carrying out a treatment plan. Medicare will pay for these services when furnished by a physician or a nonphysician practitioner or therapist as part of the patient's individualized treatment plan or therapy plan of care.

Two new codes (CPT 96202 and 96203) regarding behavior management/modification training for guardians/caregivers of patients with a mental or physical health diagnosis were created by the CPT Editorial Panel during its February 2021 meeting to be used to report the total duration of face-to-face time the physician or other qualified health professional spent providing group behavior management/modification training to guardians or caregivers of patients. After consideration of the public comments, CMS is finalizing the proposed work RVUs and direct PE inputs for CPT codes 96202 and 96203.

Telehealth Service Extensions and Updates

Telehealth-specific provisions in the PFS include:

- **In-person Requirements:** There will be a continued delay of the in-person requirements with the physician or practitioner within six months prior to the initial mental health telehealth service, as well as a regulatory change to recognize the delay of the in-person requirements for mental health visits furnished by RHCs and FQHCs through telecommunication technology until Jan. 1, 2025. CMS also directs individuals to §405.2463(b)(3), which describes the exceptions to the in-person visit requirements: If the patient and practitioner consider the risks and burdens of an in-person service and agree that, on balance, these outweigh the benefits, and if the practitioner documents the basis for that decision in the patient's medical record, then the in-person visit requirement is not applicable for that 12-month period, inclusive of situations where an in-person service is likely to cause disruption in service delivery or worsen the patient's condition(s) (86 FR 65211).

- **Originating Site Requirements:** Per the CAA 2023, the telehealth originating sites for any service on the Medicare Telehealth Services List will be temporarily expanded to include any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual's home, through Dec. 31, 2024. As discussed in the CY 2022 PFS final rule (86 FR 65059), CMS' definition of home, both in general and for this purpose, continues to include temporary lodging such as hotels and homeless shelters. As stated in that final rule, in circumstances where the patient, for privacy or other personal reasons, chooses to travel a short distance from the exact home location during a telehealth service, the service is still considered to be furnished "in the home of an individual."

- **Audio-only Services:** Consistent with CAA 2023, the Secretary shall continue to provide coverage and payment for audio-only communication systems through Dec. 31, 2024, for services on the Medicare Telehealth Services List that are permitted to be furnished via audio-only technology.

- **Place of Service for Medicare Telehealth Services*:*** Beginning in CY 2024, claims billed with POS 10 ("Telehealth provided in patient's home") will be paid at the non-facility PFS rate, and claims billed with POS 02 ("Telehealth provided other than in patient's home") will continue to be paid at the PFS facility rate, as CMS believes that this most accurately captures the resource costs inherent in these types of telehealth visits.

- **Direct Supervision via Use of Two-way Audio/Video Communications Technology:** CMS is finalizing the proposal to continue to define direct supervision to permit the presence and "immediate availability" of the supervising practitioner through real-time audio and visual interactive telecommunications through Dec. 31, 2024. This definition of direct supervision to permit virtual presence in RHCs and FQHCs will also be extended through Dec. 31, 2024. Additionally, CMS notes the potential that this expansion of direct supervision to include virtual presence may be permanently established.

Medicare and Medicaid Provider and Supplier Enrollment

CMS is finalizing the proposed regulatory provision to require all Medicare provider and supplier types to report additions, deletions or changes in their practice locations within 30 days.

Summary of 2024 Hospital Outpatient Prospective Payment System Final Rule (CMS-1786-FC)

Also on Nov. 2, 2023, CMS finalized its final rule with comment period for CY 2024 Hospital Outpatient Prospective Payment System (OPPS), which establishes Medicare payment rates for hospital outpatient and Ambulatory Surgical Center (ASCs) services. The final rule is scheduled for publication on Nov. 22, 2023, and will be effective Jan. 1, 2024. National Council also provided comment on the proposal in September 2023. See the CY 2024 OPPS final rule issued in the Federal Register and CMS' fact sheet for more information.

Overall, OPPS payment rates will increase by 3.1% for 2024. Notably, in the final rule regarding policy implications for behavioral health services, CMS is establishing intensive outpatient program (IOP) services under Medicare furnished in hospital outpatient departments, Community Mental Health Centers (CMHCs), FQHCs, and RHCs, as well as in OTPs for OUD. The final rule codifies certification and plan-of-care treatment requirements for IOP and Partial Hospitalization Program (PHP) services, as well as establishes four payment rate methodologies for IOP and PHP services. CMS is also finalizing changes to CMHC Conditions of Participation (CoPs).

PHP Updates

Revisions to PHP Physician Certification Requirements: Consistent with the CAA 2023, CMS is finalizing the proposal to codify in regulation at §424.24(e)(1)(i) the requirement for a physician to determine that

each patient needs a minimum of 20 hours of PHP services per week and maintains that the first recertification of PHP services must occur as of the 18th day of PHP services. This determination must occur no less frequently than monthly.

Explicit Reference to SUD in PHP: After consideration of the public comments received and the misconception that Medicare does not cover PHP for the treatment of SUD, CMS is finalizing an amendment to the PHP regulations at §410.43(a)(4)(i) and (iii) to include references to SUD professionals and patients with SUD, respectively, as well as at §410.43(c)(5) to include references to SUD diagnoses.

IOP as a New Medicare Benefit

IOP Established as a Benefit Under Medicare: Consistent with the CAA 2023, Medicare will cover IOP services furnished on or after Jan. 1, 2024, by a hospital to its outpatients or by CMHCs, FQHCs and RHCs, as a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care, in a location other than an individual's home or inpatient residential setting.

Proposed definition of "intensive outpatient services" at 42 CFR §410.2: As proposed, CMS is finalizing that "intensive outpatient services" means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care in other than an individual's home or an inpatient or residential setting and furnishes the services as described in §410.44. CMS reports that the key distinctions between IOP and PHP can be found in the proposed regulations at §424.24(d), outlining the certification and plan of treatment requirements for IOP, which differ from PHP.

Explicit Reference to SUD in IOP: CMS is finalizing a modification to the proposed IOP regulations at §410.44 (a)(4)(i) and §410.43(a)(4)(iii) to include references to SUD professionals and patients with SUD, respectively, as well as at the proposed IOP regulation at §410.44(c)(5), to include references to SUD diagnoses.

Clarification on CMHC and Medicare Part B Enrollment: National Council expressed concern that there may be a mistaken impression that 42 CFR 489.2 means that the only clinical activities for which an entity enrolled as a CMHC may bill Medicare are PHP and IOP services, and requested clarification from CMS that nothing in the CMHC conditions for participation prevents or discourages entities enrolled as CMHCs from also being enrolled in Medicare as Part B suppliers (physician groups) furnishing outpatient behavioral health services covered under the PFS. CMS clarified that nothing in regulation, including the CMHC conditions of participation, prohibits an entity from enrolling as a CMHC and also enrolling in Medicare as a physician group to provide and bill for outpatient behavioral health services under Medicare Part B.

CMHC Provider Agreements for IOP: After consideration of the public comments CMS received, CMS is finalizing the proposals without modification to add the statutory basis for IOP at CMHCs at §488.2 and

to revise the provision at 42 CFR 489.2(c)(2) so that CMHCs may enter into provider agreements to furnish IOP services.

IOP Certification and Plan of Care Requirements: CMS is finalizing, without modification, the proposal to codify at §424.24(d) the certification and plan-of-treatment requirements for intensive outpatient services prescribed by a physician for an individual determined (not less frequently than once every other month) to have a need for such services for a minimum of nine hours per week, and that this certification must occur no less frequently than once every other month. There is no requirement to certify that IOP patients would need inpatient hospitalization if they did not receive such services, which is required for PHP patients.

FQHC and RHC IOP Services: CMS is finalizing the proposed adoption of the same standards for physician certification and plan-of-care requirements for IOP services furnished in RHCs and FQHCs as in the outpatient hospital and CMHC settings. CMS clarified that, regarding RHCs and FQHCs, they believe that peer support specialists are considered auxiliary personnel.

OTP IOP Services: While CAA, 2023 did not address coverage for IOP services furnished in OTPs, CMS is establishing payment under Part B for IOP services furnished by OTPs for the treatment of OUD for CY 2024 and subsequent years. CMS is finalizing that, for certification and plan-of-care requirements for OTP IOP services, a physician and/or nonphysician practitioner could perform such requirements and recertification, and that the first recertification and subsequent recertifications for OTP intensive outpatient services must occur no less frequently than every 60 days, consistent with §424.24(d)(3)(ii).

Exclusion of IOP Services from the Outpatient Mental Health Treatment Limitation: Consistent with the CAA 2023, CMS is finalizing as proposed an amendment to the regulations at §410.155(b)(2)(iii) to state that intensive outpatient services not directly provided by a physician are not subject to the outpatient mental health treatment limitation.

Terminology: CMS stated that the inclusion of SUD and behavioral health diagnoses among the patient eligibility criteria for PHP services is consistent with their longstanding policy. However, they noted that interested parties have raised concerns that this policy may not be clear, and thus they clarified that the term “mental health diagnosis” as used at both §410.43(c)(5) and §410.44(c)(5) would include SUD and behavioral health diagnoses.

Coding, Billing and Payment Rate for PHP and IOP Under the OPPS

HCPCS Coding: In the CY 2024 OPPS/ASC proposed rule, CMS explained that, since the statutory definitions of both IOP and PHP generally include the same types of items and services covered, they believe it is appropriate to align the programs using a consistent list of services so that level of intensity would be the only differentiating factor. CMS stated its belief that the level of intensity of mental health services a patient requires may vary over time; therefore, they believe utilizing a consolidated list of HCPCS codes to identify services under both the IOP and PHP benefits would ensure a smooth transition for patients when a change in the intensity of their services is necessary to best meet their needs.

Additionally, CMS will add new codes through sub-regulatory guidance and that they would be payable when furnished by a PHP or IOP.

Required Primary List Services for PHP or IOP: CMS is finalizing that at least one service must be from the Partial Hospitalization and Intensive Outpatient Primary Services list to qualify for the PHP or IOP Ambulatory Payment Classification (APC). The final list of PHP and IOP primary services is found on Table 99.

Additional HCPCS Codes for PHP and IOP: CMS is adopting HCPCS codes as applicable for PHP and IOP for caregiver-focused services and PIN services inclusive of peer support specialists (which will not count toward payment requirement of three or four services per day). The final list HCPCS codes applicable for PHP and IOP for CY 2024 can be found in Table 98.

Payment Rate Methodology for PHP and IOP: CMS is finalizing the proposal to establish separate APC per diem payment rates for PHP IOP days with three services and four or more services and to establish separate APC per diem payment rates for CMHCs and hospital-based PHPs. CMS is also finalizing the proposal to set APC per diem payment rates for IOP days based on the APC per diem payment rates for PHP in CY 2024. Lastly, CMS is finalizing the proposal to make payment at the three-service rate for PHP or IOP days that have fewer than three services. CMS is not adopting the commenters' recommendation to finalize the alternative site neutral payment rates for this CY 2024 OPPS/ASC final rule but will take these comments into consideration to potentially inform future rulemaking. The final CY 2024 PHP and IOP APC geometric mean per diem costs are shown in Table 101.

Specific Payment Rules for FQHCs and RHCs: RHCs will be paid the three-services-per-day payment amount for hospital outpatient departments. For FQHCs, payment will be the lesser of an FQHC's actual charges or the three-services-per-day payment amount for hospital outpatient departments. For grandfathered Tribal FQHCs, payment will be the Medicare outpatient per-visit rate as established by the IHS when furnishing IOP services, and payment is based on the lesser of a grandfathered Tribal FQHC's actual charges or the Medicare outpatient per visit rate. CMS clarified that if a mental health visit is furnished on the same day as IOP services, all services are covered under Medicare Part B; however, CMS will only pay the IOP rate, and the mental health visit will be packaged. In response to the National Council's comment, CMS acknowledged that while there could be emergency circumstances for which a mental health visit and IOP services are furnished, they believe this occurrence is unlikely and contend that the payment amount is adequate if these situations do occur.

OTP Payment Adjustment: CMS is establishing a weekly payment adjustment for IOP services furnished by OTPs. The adjustment will be made when at least nine OTP intensive outpatient services are furnished in a week. CMS is also finalizing a payment methodology based on the estimated payment rate of three services per day for hospital-based IOPs.

Payment for Nonexcepted Off-Campus Hospital Outpatient Departments: CMS is finalizing the proposal to apply the CMHC PHP and IOP per diem rates as the MPFS rates for PHP and IOP services furnished by nonexcepted off-campus PBDs.

CMHC Updates and CoPs Changes

CMHC Definition to Refer to IOP: CMS proposed to revise the definition of "Community Mental Health Center (CMHC)" at § 410.2 to refer to intensive outpatient services and clarified that the definition would allow a CMHC to be considered a participating provider of both partial hospitalization services and intensive outpatient services but would not require a CMHC to provide both types of services to be considered as participating.

Outlier Policy for CMHCs: For CY 2024, CMS finalized as proposed an update to the calculations of the CMHC outlier percentage, cutoff point and percentage payment amount, outlier reconciliation, outlier payment cap, and fixed dollar threshold according to previously established policies to include intensive outpatient services, as they anticipate that total payments will increase for CMHCs in CY 2024. CMS explained that they disagree with using a site-neutral payment to eliminate the need for a separate outlier policy for CMHCs.

IOP in CMHC CoPs: The CAA, 2023 established coverage of intensive outpatient services in CMHCs in §4124. Consistent with this change, CMS is finalizing, as proposed, to modify the requirements for CMHCs to include IOP services throughout the CoPs. They are also finalizing the proposal to modify the CMHC CoPs for personnel qualifications to add a definition of MFTs and revise the current definition of MHCs. In addition, they are adding MFTs and MHCs to the list of practitioners who can lead interdisciplinary team meetings when deemed necessary.

CMS acknowledged the content of comment National Council raised under this section. In response to comment encouraging CMS to monitor and require state Medicaid agencies to monitor the challenges faced by CMHCs obtaining secondary payment from state Medicaid agencies for PHP and IOP services, CMS agreed this is an important issue and will share this information with the appropriate CMS component for their review. In response to comments regarding the impact of the requirement for CMHCs to provide at least 40% of their items and services to individuals who are not eligible for Medicare, CMS expressed appreciation for the feedback and said they will continue to consider this further.

MFT/MHC Provisions

Inclusion of MFTs and MHCs in IOP and PHP Services: Although CMS did not propose to name MHCs or MFTs in the regulatory language of §410.43(a) or §410.44(a), CMS clarified that the services of these providers, when furnished to PHP or IOP patients, would constitute services of "other mental health professionals" under §410.43(a)(4)(i) and §410.44(a)(4)(i). Commenters requested that §410.27, which permits certain hospital services to be furnished incident to a physician or nonphysician practitioner's service, be updated to expand the definition of "nonphysician practitioner" to include MFTs and MHCs.

CMS is amending the regulation at 42 CFR 410.27(g) to revise the definition of "nonphysician practitioner" to include MFTs and MHCs, consistent with section 4121 of the CAA 2023 and the amendments to the regulations at §410.53 and §410.54 that they are adopting in the CY 2024 PFS final rule.

Additionally, in the PFS rule, CMS clarified that MFT and MHC services should not be billed separately when provided to PHP or IOP patients, because those services are included within the overhead costs and support staff costs which the provider receives through the per diem PHP or IOP payment. Commenters also sought clarification in relation to MFT and MHC services that are not paid under OPPS. CMS stated that, because MHC and MFT services are professional services of nonphysician practitioners for which payment is made under the PFS, in implementing the CAA 2023, CMS must also exclude these services from payment under the OPPS effective Jan. 1, 2024. Thus, CMS is also amending the regulation at 42 CFR 419.22 to add the services of MFTs as defined in §1861(lll)(1) and the services of MHCs as defined in §1861(lll)(3) to the list of hospital services excluded from payment under the OPPS, at new sections (w) and (x), respectively.