determination of the need for PHP services at least 20 hours per week must occur no less frequently than monthly.

Comment: Overall, commenters agreed that the proposed modification to the regulation at § 424.24(e)(1)(i) is consistent with the CAA, 2023 requirement that the physician certifies the need for PHP services for at least 20 hours per week. One commenter recommended CMS consider allowing any addiction treatment professional operating within their scope of practice under state regulation to certify the need for PHP for SUD treatment.

Response: We appreciate the commenters' support. Section 4124(a) of the CAA, 2023 specifically states that the certification must be determined by a physician. Section 1861(r) of the Act defines ''physician'' as a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. Therefore, we do not believe we are able to expand the certification of the need for PHP services to any addiction treatment professional.

Comment: Commenters recommended that CMS reconsider the timing associated with the initial PHP recertification requirement. Commenters noted section 1861(ff)(1) of the Act, as amended by section 4124(a) of the CAA, 2023, specifies that recertification should occur ''not less frequently than monthly''. The commenters further noted that the current regulation at § 424.24(e)(3)(ii) requires the initial PHP recertification as of the 18th day of partial hospitalization services, which is significantly earlier than one month after the patient begins receiving PHP services. The commenters stated it may be clinically beneficial for the PHP to have more days of furnishing partial hospitalization before determining whether recertification is warranted for the person.

Response: We appreciate the commenter's concerns regarding the timing of the first recertification of PHP services. We did not propose to modify the regulation at § 424.24(e)(3)(ii) which requires the first recertification of PHP services occur as of the 18th day of partial hospitalization services. As discussed in the April 2000 OPPS final rule with comment period (65 FR 18454), because partial hospitalization is the outpatient substitute for inpatient psychiatric care, we stated that we believed it was appropriate to adopt the standard used for inpatient psychiatric care at that time. The requirement for initial recertification by the 18th day of an inpatient psychiatric *stay* was codified in regulation at § 424.14(d)(2) in the March 1988 final rule with comment period (53 FR 6636 and 6637). We later modified the initial recertification interval from 18 days to 12 days. As we explained in the RY 2007 IPF PPS final rule (71 FR 27076 and 27077), the standard for IPF initial recertification was determined by the average length of stay (LOS) for inpatient psychiatric hospitalization in the 1980s, which was 18 days. For RY 2007, we amended the regulation at § 424.14(d)(2) to require the initial recertification for IPF patients as of the 12th day of hospitalization. This change was based on analysis of the MedPAR 2002 claims data for IPF services. Although the timing requirement for inpatient psychiatric hospitalization was shortened, we continue to believe that the current timing requirements for PHP initial recertification—that is, as of the 18th day of PHP services—is appropriate. We note that our analysis shows that 18 days generally corresponds to the median length of stay for PHP patients.

Final Decision: After consideration of the public comments we received, we are finalizing our proposed revision to the regulation at § 424.24(e)(1)(i) to require the physician certification for PHP services include a certification that the patient requires such services for a minimum of 20 hours per week.

B. Intensive Outpatient Program Services

1. Establishment of Intensive Outpatient Services Benefit by Section 4124 of the CAA, 2023

Section 4124(b) of the CAA, 2023 established Medicare coverage for intensive outpatient services effective for items and services furnished on or after January 1, 2024. Section 4124(b)(1)(A) of the CAA, 2023 amended section 1832(a)(2)(J) of the Act to add intensive outpatient services to the scope of covered benefits provided by CMHCs, and section 4124(b)(1)(B) amended section 1861(s)(2)(B) to add intensive outpatient services to the definition of ''medical and other health services'', specifically, as a service furnished ''incident to a physicians' services.''

Intensive outpatient services are furnished under an intensive outpatient program (IOP). Similar to PHP, an IOP is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness, which includes, but is not limited to, conditions such as depression, schizophrenia, and SUD. Generally speaking, an IOP is thought to be less intensive than a PHP, and the statutory definition of IOP services reflects this difference in intensity. Specifically, section 4124(b)(2)(B) of the CAA, 2023 amended section 1861(ff) of the Act to add a new paragraph (4) to define the term ''intensive outpatient services'' as having the same meaning as ''partial hospitalization services'' in paragraph (1). In particular, intensive outpatient services are the items and services described in paragraph (2) prescribed by a physician for an individual determined (not less frequently than once every other month) by a physician to have a need for such services for a minimum of 9 hours per week and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan. For patients of an IOP, section 1835(a)(2)(F)(i) of the Act does not apply, that is, individuals receiving IOP would not require inpatient psychiatric care in the absence of such services. Lastly, section 4124(b)(2)(B) of the CAA, 2023 further added to section 1861(ff)(4)(C), which cross-references paragraph (3), that an IOP is a program furnished by a hospital to its outpatients, or by a community mental health center (CMHC), a Federally qualified health center (FQHC), or a rural health clinic (RHC), 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 or residential setting. Section 4124(c) of the CAA, 2023 amends section 1834 of the Act by adding a new paragraph (5) to subsection (o) and a new paragraph (3) to subsection (y), which include special payment rules for intensive outpatient services furnished in FQHCs and RHCs, which are discussed in greater detail in section VIII.F of this final rule with comment period.

This final rule establishes payment and program requirements for the IOP benefit in all of the above-described settings. Section VIII.B.2 of this final rule with comment period discusses the scope of benefits for IOP services, and section VIII.B.3 of this final rule with comment period discusses physician certification requirements. Section VIII.C of this final rule with comment period discusses coding and billing for

both PHP and IOP services under the OPPS beginning in CY 2024. Section VIII.D of this final rule with comment period discusses the payment methodology. Section VIII.E of this final rule with comment period discusses the outlier policy for CMHCs. Section VIII.F of this final rule with comment period discusses payment for IOP services in FQHCs and RHCs, and section VIII.G of this final rule with comment period discusses payment for IOP services in Opioid Treatment Programs (OTPs).

2. IOP Scope of Benefits

Section 1861(ff)(2) of the Act describes the items and services available under the IOP benefit. These items and services include: individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law); occupational therapy requiring the skills of a qualified occupational therapist; services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered); individualized activity therapies that are not primarily recreational or diversionary; family counseling (the primary purpose of which is treatment of the individual's condition); patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment); diagnostic services; and such other items and services as the Secretary may provide (excluding meals and transportation) that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish, taking into account accepted norms of medical practice and the reasonable expectation of patient improvement.

Consistent with the statutory definition of intensive outpatient services under section 1861(ff)(2) of the Act, we proposed to add regulations at 42 CFR 410.44 to set forth the conditions and exclusions that would apply for intensive outpatient services. Consistent with the existing regulations for partial hospitalization services, we proposed to require that intensive outpatient services must be furnished in accordance with a physician certification and plan of care. However, where partial hospitalization requires the physician to certify that the services are instead of inpatient hospitalization, intensive outpatient program services are not intended for those who otherwise need an inpatient level of care. That is, section 1861(ff)(4)(A) of the Act, as added by section 4124 of the CAA, 2023, states that for intensive outpatient services, section 1835(a)(2)(F)(i) of the Act shall not apply. As further discussed in section VIII.B.3 of this final rule with comment period, we proposed to add language to the regulation at § 424.24(d), which is currently reserved, that would set forth the physician certification and plan of care requirements for intensive outpatient services.

Additionally, we proposed to revise certain existing regulations at §§ 410.2, 410.3, 410.10, 410.27, 410.150, and 419.21 to add a regulatory definition of intensive outpatient services and to include intensive outpatient services in the regulations for medical and other health services paid for under Medicare Part B, and in the case of § 419.21, under the OPPS. We proposed to create regulations at § 410.111 to establish the requirements for coverage of IOP services furnished in CMHCs, and at § 410.173 to establish conditions of payment for IOP services furnished in CMHCs. Lastly, we proposed to revise § 410.155 to exclude IOP services from the outpatient mental health treatment limitation, consistent with the statutory requirement of section 1833(c)(2) of the Act, as amended by section 4124(b)(3) of the CAA, 2023. We discuss our proposals and the comments we received in the following paragraphs.

a. Definition of Intensive Outpatient Services

We proposed the following definition at § 410.2 for intensive outpatient services: *Intensive outpatient services* means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in § 410.44. Intensive outpatient services are not required to be provided in lieu of inpatient hospitalization. We noted that the proposed definition for intensive outpatient services is consistent with the statutory requirements of section 1861(ff)(3)(A), which apply to both IOP and PHP services. Accordingly, the proposed definition is largely consistent with the existing regulatory definition of partial hospitalization services. However, in accordance with section 1861(ff)(4)(A) of the Act, as added by the CAA, 2023, we included a clarification in the regulatory definition of ''intensive outpatient services'' that they are not required to be provided in lieu of inpatient hospitalization. We stated that we included this clarification in order to more clearly differentiate between the definitions of partial hospitalization and intensive outpatient at § 410.2.

Comment: Commenters were generally supportive of the proposed definition at § 410.2 for intensive outpatient services. However, commenters recommended that language specifying IOP represents a less intensive service than partial hospitalization be included in the definition. The commenters stated this addition could avoid any misconception that IOP is substantively different from PHP.

Response: We thank commenters for their suggestions. We proposed the regulations for IOP to be similar to PHP due to the similarities of both programs as enacted by section 4124(b) of the CAA, 2023. The key distinctions between IOP and PHP can be found in the proposed regulations at § 424.24(d). The proposed regulations at § 424.24(d) outline the content of certification and plan of treatment requirements for IOP, which differ from PHP requirements. Specifically, proposed regulations at § 424.24(d)(1) do not include a requirement that individuals receiving IOP would require inpatient psychiatric care in the absence of such services, which is required under PHP at § 424.24(e)(1)(i). Additionally, the proposed modification to the PHP regulation at § 424.24(e)(1)(i) requires individuals receiving PHP be certified by a physician to need a minimum of 20 hours per week of such services; while the proposed IOP regulation at § 424.24(d)(1)(i) requires individuals receiving IOP be certified by a physician to need a minimum of 9 hours per week of such services. Therefore, we believe the proposed definition at § 410.2 for intensive outpatient services sufficiently defines an intensive outpatient program.

Comment: A few commenters were concerned CMS did not propose to include IOP services furnished remotely. Commenters noted how the availability of remote PHP services during the COVID–19 public health emergency (PHE) has increased access to these services, especially in rural areas. The commenters stated remote IOP services would also be beneficial to increase access to the benefit.

Response: We appreciate the comments on how the availability of remote services increased access during the COVID–19 PHE. Section

1861(ff)(3)(A) of the Act does not allow Medicare to pay for partial hospitalization services furnished to beneficiaries in a home or residential setting. As discussed in the CY 2023 OPPS/ASC final rule with comment period (87 FR 72000 through 72002), we did not propose to recognize OPPS remote services, as described in section X.A.5 of the CY 2023 OPPS/ASC final rule with comment period (87 FR 72014 through 72017), as PHP services, because we do not have statutory authority to pay for services furnished in a home or residential setting as partial hospitalization services. However, we clarified that none of the PHP regulations would preclude a patient that is under a PHP plan of care from receiving other reasonable and medically necessary non-PHP services from a hospital. This means that patients in a PHP are not precluded from receiving remote mental health services provided outside of the PHP by the same or another hospital, when such services are reasonable and medically necessary. In response to IOP services being furnished remotely to beneficiaries in their homes, we note that section 1861(ff) of the Act, as amended by section 4124(b)(2)(B) of the CAA, 2023 adopts much of the statutory definition for PHP and applies it to IOP. Specifically, section 1861(ff)(3)(A) prohibits both PHP and IOP services from being furnished other than in an individual's home or in an inpatient or residential setting. However, as we discussed in the CY 2023 OPPS/ASC final rule with comment period for PHP, we are clarifying in this final rule that none of the proposed IOP regulations would preclude a patient that is under an IOP plan of care from receiving other reasonable and medically necessary non-IOP services from a hospital.

Additionally, we are reiterating and clarifying in this final rule that we would expect that a physician would update the patient's PHP or IOP plan of care to appropriately reflect any change to the type, amount, duration, or frequency of the therapeutic services planned for that patient in circumstances when a PHP or IOP patient receives non-PHP/IOP remote mental health services from a hospital outpatient department. We also note that the medical documentation should continue to support the patient's eligibility for participation in a PHP or IOP.

Final Decision: After consideration of the public comments we received, we are finalizing the proposed definition at § 410.2 for intensive outpatient services: *Intensive outpatient services* means a distinct and organized intensive ambulatory treatment program that offers less than 24-hour daily care other than in an individual's home or in an inpatient or residential setting and furnishes the services as described in § 410.44.

The conditions and exclusions for partial hospitalization services are included in the regulation at § 410.43. We proposed that the conditions and exclusions for intensive outpatient services would be included in new regulations at § 410.44.

At new § 410.44, we proposed to establish regulatory language for intensive outpatient services that is consistent with the existing language for partial hospitalization conditions and exclusions and the statutory definition of intensive outpatient services. Specifically, under § 410.44(a) we proposed that IOP services are services that: (1) are reasonable and necessary for the diagnosis or active treatment of the individual's condition; (2) are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization; (3) are furnished in accordance with a physician certification and plan of care as specified under new regulations at § 424.24(d); and include any of the services listed in § 410.44(a)(4). Under § 410.44(a)(4), we include a list of the types of services that we proposed would be covered as intensive outpatient services:

- Individual and group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State law.
- Occupational therapy requiring the skills of a qualified occupational therapist, provided by an occupational therapist, or under appropriate supervision of a qualified occupational therapist by an occupational therapy assistant as specified in part 484.
- Services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients.
- Drugs and biologicals furnished for therapeutic purposes, subject to the limitations specified in § 410.29.
- Individualized activity therapies that are not primarily recreational or diversionary.
- Family counseling, the primary purpose of which is treatment of the individual's condition.
- Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment.
- Diagnostic services.

The proposed list at § 410.44(a)(4) is based on the list of items and services described in section 1861(ff)(2) of the Act. We note that 1861(ff)(2) of the Act also provides that intensive outpatient services may include such other items and services as the Secretary may provide (but in no event to include meals and transportation). As discussed in section VIII.C of this final rule with comment period, we solicited comments on whether additional codes should be added to the list of services recognized as appropriate for PHP and IOP. We discuss the comments we received and provide our responses in that section of this final rule with comment period, and we note that none of the codes we are adopting in that section of this final rule with comment period necessitate changes to the proposed list at § 410.44(a)(4).

In the proposed rule, we further noted that both the statute at section 1861(ff)(2)(C) of the Act and our proposed regulation at § 410.44(a)(4)(iii) refer to ''trained psychiatric nurses, and other staff trained to work with psychiatric patients.'' We explained that under our longstanding policy for partial hospitalization services, we have considered nurses and other staff trained to work with patients within their state scope of practice who are receiving treatment for SUD to be included under this statutory definition and the regulatory definition of PHP at § 410.43(a)(4). We stated that we have heard from interested parties that there could be a misconception that Medicare does not cover PHP for the treatment of SUD. We are clarifying that, in general, notwithstanding the requirement that PHP services are provided in lieu of inpatient hospitalization, Medicare covers PHP for the treatment of SUD, and we consider services that are for the treatment of SUD and behavioral health generally to be consistent with the statutory and regulatory definition of PHP. We clarified in the proposed rule that the terms ''trained psychiatric nurses, and other staff trained to work with psychiatric patients,'' as used in §§ 410.43(a)(4) and 410.44(a)(4) would include trained SUD nurses and other staff trained to work with SUD patients. Under § 410.44(b), we proposed that the following services are separately covered and not paid as intensive outpatient services: (1) physician services; (2) physician assistant services; (3) nurse practitioner and clinical nurse specialist services; (4) qualified psychologist services; and (5) services furnished to residents of a skilled nursing facility (SNF). We note that these proposed exclusions are consistent with the services excluded from payment as partial hospitalization

program services at § 410.43(b). The services listed under §§ 410.43(b) and 410.44(b) would be paid under the applicable systems for such services.

Lastly, under § 410.44(c), we proposed to establish patient eligibility criteria for intensive outpatient services. Specifically, we proposed that intensive outpatient services are intended for patients who: (1) require a minimum of 9 hours per week of therapeutic services as evidenced in their plan of care; (2) are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment; (3) do not require 24-hour care; (4) have an adequate support system while not actively engaged in the program; (5) have a mental health diagnosis; (6) are not judged to be dangerous to self or others; and (7) have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the intensive outpatient program.

We noted that these proposed patient eligibility criteria at § 410.44(c) are consistent with the existing partial hospitalization patient eligibility criteria at § 410.43(c). With respect to the proposed criterion of a ''mental health diagnosis'', we clarified that a mental health diagnosis would include SUD and behavioral health diagnoses generally under both the existing partial hospitalization regulation at § 410.43(c)(5) and the proposed intensive outpatient services regulation at § 410.44(c)(5). As discussed earlier in this section, this inclusion of SUD and behavioral health diagnoses as among the patient eligibility criteria for PHP services is consistent with our longstanding policy. However, we noted that interested parties have raised concerns that this policy may not be clear. Therefore, we 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.

Comment: Commenters suggested the proposed regulation at § 410.44(a)(2) codifying the condition that IOP services ''are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization'' be modified. Specifically, commenters suggested the regulation at § 410.44(a)(2) be modified to read as follows: ''Are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or worsening of the individual's condition.'' The commenters stated that as IOP is not provided in lieu of hospitalization, more expansive language may be appropriate.

Response: We appreciate the concern that commenters raised that more expansive language may be appropriate for patients of an IOP. As discussed above, at new § 410.44, we proposed to establish regulatory language for intensive outpatient services that is consistent with the existing language for partial hospitalization conditions and exclusions and the statutory definition of intensive outpatient services. The regulatory language for IOP and PHP is derived from the language of section 1861(ff)(2) of the Act. We do not believe it is appropriate to revise the language for IOP.

Comment: A majority of commenters appreciated the clarification that the terms ''trained psychiatric nurses, and other staff trained to work with psychiatric patients,'' as referenced in § 410.43(a)(4) and proposed § 410.44(a)(4) would include trained SUD nurses and other staff trained to work with SUD patients; however, they requested CMS codify this interpretation in the regulations. Specifically, commenters requested that CMS amend the regulations at § 410.43(a)(4)(i) and (iii), proposed § 410.44(a)(4)(i) and (iii) for PHP and IOP, respectively, to include services furnished by SUD counselors, and reference individuals with mental health or SUD diagnoses. In addition, commenters requested CMS amend § 410.43(c)(5) and proposed § 410.44(c)(5) to reference ''mental health or SUD diagnosis'' as acceptable for both the PHP and IOP benefits.

Response: As discussed in the CY 2024 OPPS/ASC proposed rule (88 FR 49700 and 49701) under our longstanding policy for partial hospitalization services, we have considered nurses and other staff trained to work with patients within their state scope of practice who are receiving treatment for SUD to be included under this statutory definition and the regulatory definition of PHP at § 410.43(a)(4). After consideration of the public comments received, and the misconception we have heard that Medicare does not cover PHP for the treatment of SUD, we are finalizing an amendment the PHP regulations at § 410.43(a)(4)(i) and (iii) to include references to SUD professionals and patients with SUD, respectively. Additionally, we are 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. Furthermore, we are finalizing a modification to the PHP regulation at § 410.43(c)(5), as well as the proposed IOP regulation at § 410.44(c)(5), to include references to SUD diagnoses.

We remind readers that the inclusion of SUD in these regulations does not change the applicability of any other existing PHP regulations or proposed IOP regulations. In all cases, these services must be reasonable and necessary, furnished in accordance with a physician certification and plan of treatment, and provided by an individual working within his or her scope of practice. Further, in the case of PHP services for the treatment of SUD, such services must be provided in lieu of inpatient hospitalization.

Comment: Some commenters requested that CMS amend the regulation at § 410.43(a)(4)(iii) to specifically reference that the services of marriage and family therapists (MFTs) and mental health counselors (MHCs) comprise a portion of partial hospitalization services; while other commenters requested CMS amend the regulatory exclusions at § 410.43(b) and proposed § 410.44(b) of PHP and IOP, respectively, to encompass the professional services of MFTs and MHCs.

Response: As we discussed in the 2000 OPPS final rule (65 FR 18452), payment for partial hospitalization services under the OPPS represents the provider's overhead costs, support staff, and the services of clinical social workers (CSWs) and occupational therapists (OTs), whose professional services are considered to be partial hospitalization services for which payment is made to the provider. These same components of cost discussed in that 2000 OPPS final rule were used to determine the per diem costs for both PHP and IOP for this CY 2024 OPPS/ASC final rule. Although we did not propose to name MHCs or MFTs in the regulatory language of § 410.43(a) or § 410.44(a), 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). We did not propose to exclude MHCs or MFTs under § 410.43(b) or § 410.44(b), and in accordance with our longstanding policy, to maintain the historical patterns of treatment billed during the base year, we are clarifying that the services of MFTs and MHCs are considered to be partial hospitalization and intensive outpatient services. The services of MFTs and MHCs should not be billed separately when provided to PHP or IOP patients, because they are included within the overhead costs and costs for support staff which are made

to the provider through the per diem PHP or IOP payment.

Comment: Commenters requested CMS remove the proposed regulation at § 410.44(c)(4) which states an IOP is intended for patients who have an adequate support system while not actively engaged in the program. Commenters noted that while mental health outcomes are enhanced by a patient's support system, many IOP patients have housing insecurities or are at risk of being housing insecure. The commenters stated conditioning treatment on a patient's support system may prohibit patients from enrolling in an IOP.

Response: As discussed in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68695) our goal is to improve the level of service furnished in a PHP day, while also ensuring that the partial hospitalization benefit is being utilized by the appropriate population. In addition, for the program to be fully beneficial, a PHP participant should have a strong support system outside of the PHP program to help to ensure success. We also believe having a strong support system outside of the IOP program to help ensure success will further our goal to improve the level of service across the mental health continuum of care.

Final Decision: After consideration of the public comments we received, we are finalizing the proposed regulations at § 410.44 with modifications to include references to SUD. In addition, we are modifying the parallel existing regulations for PHP at § 410.43 to include the same references to SUD.

b. Coverage of IOP as Medical and Other Health Services Paid under Part B

We proposed to amend the regulation at § 410.10(c) to add a reference to ''intensive outpatient services'' to the list of services that are covered as medical and other health services under Part B, when furnished as hospital or CAH services incident to a physician's professional services. We believe this is consistent with section 1861(s)(2)(B) of the Act, as amended by section 4124(b)(1)(B) of the CAA, 2023 to include ''intensive outpatient services'' under the definition of medical and other health services; specifically, hospital services incident to a physicians' services. We note that the services described at § 410.10(c) are furnished by a hospital or CAH. Accordingly, we proposed conforming changes to the regulations at § 410.27(a)(2) and (e) introductory text to include references to intensive outpatient services.

We did not receive any public comments on our proposal, and we are finalizing our proposal without modification to amend the regulation at § 410.10(c) to add a reference to ''intensive outpatient services'' to the list of services that are covered as medical and other health services under Part B, when furnished as hospital or CAH services incident to a physician's professional services. Additionally, we are finalizing our proposal to codify conforming changes to the regulations at § 410.27(a)(2) and (e) introductory text to include references to intensive outpatient services.

c. Technical Changes to Codify Requirements for IOP at CMHCs

We proposed technical changes to the regulations at 42 CFR parts 488 and 489.

First, we proposed to add the statutory basis for IOP at CMHCs at § 488.2. The proposed technical revision would add section 1832(a)(2)(J) of the Act, which sets forth the statutory basis of intensive outpatient services provided by CMHCs at § 488.2.

We also proposed to revise the provision at 42 CFR 489.2(c)(2) so that CMHCs may enter into provider agreements to furnish intensive outpatient services. We proposed to revise the current requirement that allows for CMHCs to enter into provider agreements only for the provision of partial hospitalization services. The proposed revisions to this provision would allow CMHCs to enter into provider agreements only to furnish partial hospitalization services and intensive outpatient services.

Comment: Commenters 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. The commenters requested CMS clarify 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 Physician Fee Schedule (PFS).

Response: We thank the commenters for raising concerns about a potential misinterpretation of § 489.2 to mean that an entity enrolled as a CMHC may only bill Medicare for PHP and IOP services. In response to these concerns, we are clarifying 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. In fact, CMHC conditions of participation at § 485.918(b) require CMHCs to provide a broad array of outpatient behavioral health services to the individuals they serve. When billing for PHP or IOP, the CMHC would submit a facility bill for payment under the OPPS at the applicable PHP or IOP per diem rate. When billing for other outpatient behavioral health services under Medicare Part B, including services for PHP and IOP patients that are excluded under §§ 410.43(b) and 410.44(b) and paid separately, the billing practitioner would bill for the services provided, subject to all applicable billing requirements under the PFS. We also note that CMHC conditions of participation under part 485, subpart J, apply to all patients of the CMHC, so if a patient is discharged from a PHP or IOP and begins receiving behavioral health services billed under Medicare Part B, the CMHC conditions of participation would continue to apply.

Final Decision: After consideration of the public comments we received, we are finalizing our 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.

d. Technical Changes to Codify Coverage of IOP at CMHCs

We proposed several technical changes and additions to the regulations at §§ 410.2, 410.3, 410.111, 410.150, and 410.173.

First, we proposed to revise the definition of ''Community Mental Health Center (CMHC)'' at § 410.2 to refer to intensive outpatient services. Specifically, we proposed to revise the regulation to state that a CMHC is an entity that provides day treatment or other partial hospitalization services or intensive outpatient services, or psychosocial rehabilitation services. Second, we proposed to revise the definition of ''Participating'' at § 410.2 to refer to intensive outpatient services as services that CMHCs can provide. Specifically, we proposed that ''Participating'' refers to a CMHC that has in effect an agreement to participate in Medicare, but only for the purposes of providing partial hospitalization services and intensive outpatient services. We clarified that the proposed 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 in order to be considered participating.

Comment: Commenters appreciated the clarification that organizations need not furnish both PHP and IOP in order to qualify as a CMHCs and were generally supportive of the proposed regulation at § 410.2 to refer to intensive outpatient services as part of the definition of ''Community Mental Health Center (CMHC)''. However, commenters requested clarification on why the reference to psychosocial rehabilitation is included in the definition of CMHC. The commenters stated their understanding that PHP and IOP are the only two discrete Medicare services for which CMHCs may bill the program under the CMHC enrollment.

Response: We appreciate commenters' support of the proposed definition of CMHC at regulation § 410.2. In response to the comments regarding CMHCs providing psychosocial rehabilitation, as discussed in the 1994 interim final rule with comment period (59 FR 6571) section 1916(c)(4) of the Public Health Service (PHS) Act (42 U.S.C. 300x-4(c)(4)) requires a CMHC to provide specialized outpatient services; 24-hour-a-day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screenings to determine appropriateness of admission to State mental health facilities; and consultation and education services. Accordingly, in that same interim final rule with comment period (59 FR 6577) CMS (formerly known as Health Care Financing Administration (HCFA)) finalized the definition of CMHC in regulation at § 410.2 to include an entity that provides psychosocial rehabilitation services.

In addition, we proposed to revise the scope of benefits provision at § 410.3(a)(2) to provide that the covered services for which the Medicare Part B supplementary medical insurance (SMI) program helps pay include partial hospitalization services and intensive outpatient services provided by CMHCs. We believe these proposed changes are consistent with the scope of benefits provision at section 1832(a)(2)(J) of the Act, as amended by section 4124(b)(1)(A) of the CAA, 2023 to include intensive outpatient services, as well as the proposed CMHC conditions of participation at § 485.918(b)(1)(iii). We refer readers to section XVII.B.5 of this final rule with comment period for discussion on the proposed amendments to regulations at § 485.918(b)(1)(iii).

We did not receive any public comments on our proposal and are finalizing a revision to the scope of benefits provision at § 410.3(a)(2) to provide that the covered services for which the Medicare Part B supplementary medical insurance (SMI) program helps pay include partial hospitalization services and intensive outpatient services provided by CMHCs.

In addition, subpart E of part 410 includes requirements for Community Mental Health Centers (CMHCs) Providing Partial Hospitalization Services. We proposed to modify the subpart E heading to include a reference to intensive outpatient services as well. Under subpart E, we proposed to add a new § 410.111 to set forth Requirements for coverage of intensive outpatient services furnished in CMHCs. We proposed that Medicare Part B would cover IOP services furnished by or under arrangements made by a CMHC if the CMHC has in effect a provider agreement and the services are prescribed by a physician and furnished under the general supervision of a physician, and subject to the proposed physician certification and plan of care requirements under § 424.24(d).

We did not receive any public comments on our proposals and are finalizing a modification to the subpart E heading to include a reference to intensive outpatient services, and the addition of a new § 410.111 to set forth Requirements for coverage of intensive outpatient services furnished in CMHCs.

Additionally, we proposed to revise § 410.150(b)(13) to include a reference to intensive outpatient services. Specifically, we proposed that payment would be made to a CMHC on an individual's behalf for partial hospitalization services or intensive outpatient services furnished by or under arrangements made by the CMHC.

We did not receive any public comments on our proposal and are finalizing a revision to § 410.150(b)(13) to include a reference to intensive outpatient services.

We also proposed to add a new § 410.173 to establish conditions of payment for IOP services furnished in CMHCs. We proposed to state that Medicare Part B pays for intensive outpatient services furnished in a CMHC on behalf of an individual only if the following conditions are met: (a) The CMHC files a written request for payment on the CMS form 1450 and in the manner prescribed by CMS; and (b) The services are furnished in accordance with the requirements described in § 410.111.

We did not receive any public comments on our proposal and are finalizing the addition of § 410.173 as proposed.

Lastly, we proposed to amend § 419.21(c) to refer to intensive outpatient services provided by CMHCs as services for which payment is made under the OPPS. The proposed amendment would be consistent with current regulations at § 419.21(c), which include partial hospitalization services provided by CMHCs. We note that further discussion of the payment methodology under the OPPS for intensive outpatient services is found in section VIII.D of this final rule with comment period.

Final Decision: After consideration of the public comments we received, we are finalizing the proposed technical changes and additions to the regulations at §§ 410.2, 410.3, 410.111, 410.150, and 419.21 as proposed.

e. Exclusion of Intensive Outpatient Services From the Outpatient Mental Health Treatment Limitation

Section 1833(c)(2) of the Act, as amended by section 4124(b)(3) of the CAA, 2023, excludes intensive outpatient services that are not directly provided by a physician from the term ''treatment'' for the purposes of the outpatient mental health treatment limitation under section 1833(c)(1) of the Act, similar to partial hospitalization services. Accordingly, we proposed to amend 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.

Comment: Commenters were supportive of the proposal to amend 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. However, commenters requested clarification whether the proposed regulation at 42 CFR 410.155(b)(2)(iii) means that the mental health treatment limitation does not apply to the professional services furnished to PHP or IOP participants, under the PHP or IOP plan of care, by clinicians other than physicians even though those services are billed under the Part B PFS rather than the OPPS.

Response: Under § 410.155(b)(1), services furnished by physicians and other practitioners, whether furnished directly or incident to those practitioners' services, are subject to the limitation if they are furnished in connection with the treatment of a mental, psychoneurotic, or personality disorder and are furnished to an individual who is not an inpatient of a hospital. This includes services furnished directly by physicians to PHP

and IOP patients. However, we are clarifying that since CY 2014, under current regulation at § 410.155(a)(5), 100 percent of the expenses incurred for such services during a calendar year are considered incurred expenses under Medicare Part B when determining the amount of payment and deductible.

Final Decision: After consideration of the public comments we received, we are finalizing without modification our proposed 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.

3. IOP Certification and Plan of Care Requirements

Section 4124(b)(2)(B) of the CAA, 2023 amended section 1861(ff) of the Act by adding a new paragraph (4) to define intensive outpatient services as the items and services prescribed by a physician for an individual determined (not less frequently than once every other month) by a physician to have a need for such services for a minimum of 9 hours per week. This certification must occur no less frequently than once every other month, and 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.

We proposed to codify the content of the certification and plan of treatment requirements for intensive outpatient services at § 424.24(d). Specifically, we proposed to mirror the PHP content of certification and plan of care treatment requirements at § 424.24(e), with the following exceptions: require the content of certification to include documentation that the individual requires such services for a minimum of 9 hours per week (with no requirement for the patient to need inpatient psychiatric care if the IOP services were not provided). The physician's certification of the patient's need for either IOP or PHP services should be based on the physician's determination of the patient's needs and whether the patient meets the IOP or PHP patient eligibility criteria under § 410.44(c) or § 410.43(c), respectively. We noted that the physician's certification should certify the patient's need for either IOP or PHP, and that patients participating in an IOP or PHP should not be under any other IOP or PHP plan of care for the same date of service. The patient's individualized plan of treatment should address all of the conditions that are being treated by the IOP or PHP.

Comment: Commenters disagreed that the certification for IOP services should be limited to a physician. Commenters requested that CMS explicitly allow psychiatric nurse practitioners to certify the need for IOP services and plan of care.

Response: We understand the commenter's request to expand the certification of IOP services to non-physician mental health professionals. However, section 1861(ff) of the Act, as amended by section 4124(b)(2)(B) of the CAA, 2023, specifically states the certification must be determined by a physician. Section 1861(r) of the Act defines ''physician'' as a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action. Therefore, we do not believe we have the ability to expand the certification of the need for IOP services to psychiatric nurse practitioners or other mental health professionals.

Comment: A few commenters requested that CMS revise the minimum hours per week for the IOP program from 9 hours per week to 6 hours per week. The commenters stated that IOPs should be highly flexible and reducing the number of required hours would allow a patient to ''step down'' within the confines of IOP treatment, without immediately jumping to individual mental health services.

Response: We appreciate the commenter's suggestions to provide greater flexibility within the mental health continuum of care. However, section 1861(ff) of the Act, as amended by section 4124(b)(2)(B) of the CAA, 2023 specifically states that a patient must require a minimum of 9 hours of IOP services per week. As discussed in section VIII.D.3 of this final rule with comment period, we proposed to apply the three-service payment rate (that is, payment for PHP APCs 5853 for CMHCs and 5863 for hospitals, and IOP APCs 5851 for CMHCs and 5861 for hospitals) for days with three or fewer services while we monitor the initial utilization of IOP services. In addition, patients who do not meet the requirement of needing at least 9 hours per week of IOP services may still receive individual mental health services under the OPPS.

Additionally, we proposed to require in the regulation at § 424.24(d)(3)(ii) that the recertification of IOP services occur no less frequently than every 60 days. We stated that we believe the IOP recertification timing of no less frequently than every 60 days is consistent with the requirement in the statute that an individual be determined by a physician to have a need for IOP services ''not less frequently than once every other month'' because the minimum number of days for two consecutive months is 59 days. We stated that we believe that a consistent 60-day interval would be the most appropriate way to implement the statutory recertification requirement for IOP.

We solicited public comments on whether it would be appropriate to consider finalizing a shorter interval for the first recertification and for subsequent recertification for IOP patients. For example, we requested comments on whether we should consider requiring an initial recertification by the 30th day of IOP services, and no less frequently than every 60 days thereafter. We requested that commenters provide as much detail as possible about the rationale for a shorter recertification interval, if appropriate.

Lastly, we proposed to make conforming changes to § 424.24(b) to add a reference to paragraph (d)(1) in the list of paragraphs that specify the content for which physician certification is required for medical and other health services furnished by providers (and not exempted under § 424.24(a)) which are paid for under Medicare Part B.

Comment: Most commenters supported the proposal to require in the regulation at § 424.24(d)(3)(ii) that the recertification of IOP services occur no less frequently than every 60 days. These commenters agreed that the proposal is consistent with the CAA, 2023 requirements and that a shorter than 60-day recertification interval for IOP patients would not be beneficial.

A few other commenters stated the recertification interval should be no less frequently than every 30 days. The commenters advocating for a 30-day recertification interval argued that patients at the IOP level of care should be in a significantly more stable condition than at the PHP level of care, and after 30 days of service, should continue to improve their stability. Further, the commenters stated a 60-day recertification interval may encourage a longer length of stay and go against the preference for always keeping the patient at the least restrictive level of care.

Response: We appreciate the input from commenters. As we stated in the CY 2024 OPPS/ASC proposed rule (88 FR 49702) we believe that a consistent 60-day interval would be the most appropriate way to implement the statutory recertification requirement for IOP. We intend to monitor the provision of services and lengths of stay in the IOP program, and may consider changes to

the IOP recertification interval, if necessary, in future rulemaking.

Final Decision: After consideration of the public comments we received, we are finalizing, without modification, our proposal to codify the content of the certification and plan of treatment requirements for intensive outpatient services at § 424.24(d).

C. Coding and Billing for PHP and IOP Services Under the OPPS

1. Condition Code 41 and 92

In the CY 2024 OPPS/ASC proposed rule, we explained that we considered the similarities between the types of items and services covered by both PHP and IOP, and the larger continuum of care, when developing the proposed list of services that we believe would appropriately identify the range of services that IOPs provide to Medicare beneficiaries. Since the statutory definitions of both IOP and PHP generally include the same types of items and services covered, we stated that we 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 between partial hospitalization services and intensive outpatient services.

We noted that currently, hospital outpatient departments use condition code 41 to indicate that a claim is for partial hospitalization services. CMHCs do not currently use a condition code on the bill type used—that is, 76X—to indicate that a claim is for partial hospitalization services, because they are only considered a provider of services for partial hospitalization; and therefore, partial hospitalization services are identified by the 76X bill type. We explained that in order to differentiate between IOP and PHP for billing purposes, the National Uniform Billing Committee (NUBC) has approved a new condition code, condition code 92, to identify intensive outpatient claims. Therefore, we proposed to require hospitals and CMHCs to report condition code 92 on claims to indicate that a claim is for intensive outpatient services. We proposed to continue to require hospitals to report condition code 41 for partial hospitalization claims. Additionally, because CMHCs would be permitted to provide both PHP and IOP beginning January 1, 2024, we also proposed to require CMHCs to report condition code 41 for partial hospitalization claims. We stated that we believe this requirement would better allow us to identify which claims are for PHP and which are for IOP. We solicited comment on these proposed reporting requirements for PHP and IOP.

Comment: Commenters supported the proposal that hospitals and CMHCs report condition code 41 to identify partial hospitalization claims, and condition code 92 to identify intensive outpatient claims. The commenters agreed with the importance of distinguishing between PHP and IOP claims.

Response: We appreciate the commenters' support. Beginning January 1, 2024, we will require the use of condition code 41 on all PHP claims from hospitals and CMHCs and require the use of condition code 92 on all IOP claims from hospitals and CMHCs. We will issue operational guidance explaining the use of these condition codes in further detail.

2. Proposed HCPCS Coding for CY 2024

Under current policy, PHPs submit claims with HCPCS codes to identify the services provided during each PHP day. Therefore, we worked in conjunction with physicians to develop a consolidated list of all HCPCS codes that we believe would appropriately identify the full range of services that both IOPs and PHPs provide to Medicare beneficiaries. For reference, Table 42 includes the current list of HCPCS codes that are recognized for PHP payment. For CY 2024, we proposed to add certain codes to the list, change the descriptions of other codes, and remove one code from the list. The list of proposed consolidated HCPCS codes is included in Table 96.

We recognize that the level of intensity of mental health services a patient requires may vary over time; therefore, we 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 or their services is necessary to best meet their needs. For example, a patient receiving IOP services may experience an acute mental health need that necessitates more intense services through a PHP. Alternatively, an IOP patient that no longer requires the level of intensity provided by the IOP can access less intense mental health services, such as individual mental health services. Therefore, we proposed to add several HCPCS codes that are currently recognized as mental health codes under the OPPS, but are not recognized as PHP codes, to the list of codes that would be recognized for PHP payment. We proposed to maintain all of the existing PHP codes, except for one. We proposed to remove 90865 Narcosynthesis, because we stated that we do not believe this code is widely used in the provision of PHP, and we do not anticipate it would be widely used in the provision of IOP in the future. We proposed that the HCPCS codes listed in Table 43 of the CY 2024 OPPS/ASC proposed rule (88 FR 49704 and 49705) would be payable when furnished by PHPs or IOPs. For reference, this list of codes is reproduced in Table 96 of this final rule with comment period.

BILLING CODE 4150–28–P

TABLE 96: PROPOSED HCPCS APPLICABLE FOR PHP AND IOP

HCPCS/CPT	Short Descriptor	Proposed Action
90785	Psytx complex interactive	
90791	Psych diagnostic evaluation	
90792	Psych diag eval w/med srvcs	
90832	Psytx pt&/family 30 minutes	
90833	Psytx pt&/fam w/e&m 30 min	
90834	Psytx pt&/family 45 minutes	
90836	Psytx pt&/fam w/e&m 45 min	
90837	Psytx pt&/family 60 minutes	
90838	Psytx pt&/fam w/e&m 60 min	
90839	Psytx crisis initial 60 min	Add
90845	Psychoanalysis	
90846	Family psytx w/o patient	
90847	Family psytx w/patient	
90849	Multiple family group psytx	Add
90853	Group psychotherapy	Add
90865	Narcosynthesis	Remove
90880	Hypnotherapy	
90899	Psychiatric service/therapy	Add
96112	Devel tst phys/qhp 1st hr	Add
96116	Neurobehavioral status exam	
96130	Psychological testing evaluation by physician/qualified health care professional; first hour	
96131	Psychological testing evaluation by physician/qualified health care professional; each additional hour	
96132	Neuropsychological testing evaluation by physician/qualified health care professional; first hour	
96133	Neuropsychological testing evaluation by physician/qualified health care professional; each additional hour	
96136	Psychological/neuropsychological testing by physician/qualified health care professional; first 30 minutes	

HCPCS/CPT	Short Descriptor	Proposed Action
96137	Psychological/neuropsychological testing by physician/qualified health care professional; each additional 30 minutes	
96138	Psychological/neuropsychological testing by technician; first 30 minutes	
96139	Psychological/neuropsychological testing by technician; each additional 30 minutes	
96146	Psychological/neuropsychological testing; automated result only	
96156	Hlth bhv assmt/reassessment	Add
96158	Hlth bhv ivntj indiv 1st 30	Add
96164	Hlth bhv ivntj grp 1st 30	Add
96167	Hlth bhv ivntj fam 1st 30	Add
97151	Bhv id assmt by phys/qhp	Add
97152	Bhv id suprt assmt by 1 tech	Add
97153	Adaptive behavior tx by tech	Add
97154	Grp adapt bhv tx by tech	Add
97155	Adapt behavior tx phys/qhp	Add
97156	Fam adapt bhv tx gdn phy/qhp	Add
97157	Mult fam adapt bhv tx gdn	Add
97158	Grp adapt bhv tx by phy/qhp	Add
G0129	PHP/IOP OT service	Update
G0176	Opps/php/IOP; activity thrpy	Update
G0177	Opps/php/IOP; train & educ	Update
G0410	Grp psych PHP/IOP 45-50	Update
G0411	Interactive grp psyc PHP/IOP	Update
G0451	Development test interpt&rep	Add

We proposed to add 18 codes to the list of recognized PHP/IOP codes, as shown in Table 96 of this final rule with comment period. These codes are currently recognized as mental health codes under the OPPS, and we stated we believe it would be appropriate to recognize them for PHP and IOP as well. Additionally, we proposed to update the descriptions of five existing Level II HCPCS codes that are currently recognized for PHP to also refer to IOP.

As shown in Table 96, we proposed to add CPT code 90853 Group psychotherapy to the list of service codes recognized for PHP and IOP. We stated we believe there could be overlap between 90853 and two existing Level II HCPCS codes for PHP group psychotherapy, specifically G0410 and G0411. We stated that we considered whether it would be appropriate to remove G0410 and G0411 from the list of recognized service codes for PHP and IOP, and retain only CPT code 90853. We solicited comments on this topic, and were interested in hearing specific reasons commenters believe support either keeping G0410 and G0411 on the list or removing them. We stated that we were particularly interested in understanding whether it would be appropriate to maintain these codes on a temporary basis to provide a transition for existing PHPs that are using these codes.

We proposed to use the list of HCPCS codes in Table 96 to determine the number of services per PHP or IOP day, and therefore to determine the APC per diem payment amount for each day, as discussed in section VIII.D of this final rule with comment period. In addition, as discussed in section VIII.D of this final rule with comment period, we proposed to calculate the costs for 3-service and 4-service days based on the list of HCPCS codes in Table 96. We reminded readers that currently, to qualify for payment at the applicable PHP APC (5853 or 5863) one service must be from the Partial Hospitalization Primary list, and we identified the services that are currently included in the Partial Hospitalization Primary list along with those which we proposed to add based on our analysis of the services included on days with three and four services from the proposed list shown in Table 96 of this final rule with comment period. We proposed to maintain this requirement for CY 2024 and subsequent years to qualify for payment at the PHP or IOP APC. Thus, we proposed that to qualify for payment for an IOP APC, at least one service must be from the Partial Hospitalization and Intensive Outpatient Primary list. Specifically, we proposed that to qualify for payment for the IOP APC (5851, 5852, 5861 or 5862) or the PHP APC (5853, 5854, 5863, or 5864) one service must be from the Partial Hospitalization and Intensive Outpatient Primary list, which is reproduced in Table 97 of this final rule with comment period for reference.

TABLE 97: PROPOSED PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT PRIMARY SERVICES

HCPCS/CPT	Short Descriptor	Proposed Action
90832	Psytx pt&/family 30 minutes	
90834	Psytx pt&/family 45 minutes	
90837	Psytx pt&/family 60 minutes	
90845	Psychoanalysis	Add
90846	Family psytx w/o patient	
90847	Family psytx w/patient	
90853	Group psychotherapy	Add
90865	Narcosynthesis	Remove
90880	Hypnotherapy	
96112	Devel tst phys/qhp 1st hr	Add
96116	Neurobehavioral status exam	Add
96130	Psychological testing evaluation by physician/qualified health care professional; first hour	Add
96132	Neuropsychological testing evaluation by physician/qualified health care professional; first hour	Add
96136	Psychological/neuropsychological testing by physician/qualified health care professional; first 30 minutes	Add
96138	Psychological/neuropsychological testing by technician; first 30 minutes	Add
G0410	Grp psych partial hosp/IOP 45-50	Update
G0411	Inter active grp psych PHP/IOP	Update

BILLING CODE 4150–28–C

Lastly, we proposed that in the future, in the event there are new codes that represent the PHP and IOP services described under §§ 410.43(a)(4) and 410.44(a)(4), respectively, we would add such codes to Table 96 through sub-regulatory guidance, and that these codes would be payable when furnished by a PHP or IOP. We note that coding updates frequently occur outside of the standard rulemaking timeline. We proposed this sub-regulatory process in order to pay expeditiously when new codes are created that describe any of the services enumerated at §§ 410.43(a)(4) and 410.44(a)(4), which PHPs and IOPs, respectively, would provide. We would identify codes to be added sub-regulatorily if a new code is cross-walked to a previously included code, or if the code descriptor is substantially similar to a descriptor for a code on the list or describes a service on the list. We proposed that any additional services not described at § 410.43(a)(4) or § 410.44(a)(4) would be added to the lists in regulation through notice and comment rulemaking.

We invited public comment on the proposed consolidated list of HCPCS codes that would be payable when furnished in a PHP and IOP. As discussed in the following section of this CY 2024 OPPS/ASC final rule, we also solicited comment on any additional codes that we should consider adding. Specifically, we stated that we were interested in hearing from commenters if there are any other existing codes that CMS should consider adding to the list, or new codes that CMS should consider creating, to describe specific services not appropriately described by the codes shown in Table 96 of this final rule with comment period.

Comment: Commenters supported the removal of 90865 Narcosynthesis and agreed this code is not widely used in the provision of PHP. The commenters also supported a consolidated list of HCPCS codes that would align both the PHP and IOP benefits.

Response: We appreciate the commenters' support. After consideration of the public comments we received, we are finalizing the removal of 90865 Narcosynthesis from the list of HCPCS codes applicable for PHP and IOP.

Comment: One commenter expressed support for adding 90839 (Psytx crisis initial 60 min) to the PHP and IOP code list, but also requested that CMS include 90840 (Psytx crisis ea addl 30 min) to recognize the time associated with additional crisis psychotherapy services.

Response: We appreciate the commenter's suggestion, and we agree that this code would be appropriate to recognize for PHP and IOP. We have

included 90840 (Psytx crisis ea addl 30 min) in Table 98 of this final rule with comment period.

Comment: Commenters supported adding 90853 (Group psychotherapy) as well as maintaining G0410 (Grp psych partial hosp/IOP 45–50) and G0411 (Inter active grp psych PHP/IOP) on the list of HCPCS codes applicable to PHP and IOP. The commenters stated there are differences in the application and descriptions between these codes. Accordingly, commenters stated including codes G0410, G0411, and 90853 on the list would avoid unintentional billing errors.

Response: We appreciate the commenters' input. After consideration of the public comments we received, we are finalizing adding code 90853 Group psychotherapy and maintaining G0410 and G0411 on the list of HCPCS codes applicable to PHP and IOP. We intend to monitor the utilization of these codes and may consider changes in future rulemaking, if necessary.

Comment: Commenters supported adding codes to the list of HCPCS applicable for PHP and IOP through a sub-regulatory process when the codes added describe a service already enumerated at § 410.43(a)(4) or § 410.44(a)(4).

Response: We appreciate the commenters' support. After consideration of the public comments we received, we are finalizing our proposal to add codes to the list of HCPCS applicable for PHP and IOP through a sub-regulatory process when the codes to be added describe a service already enumerated at § 410.43(a)(4) or § 410.44(a)(4).

Comment: Commenters did not support the proposal requiring that to qualify for payment for the IOP APC (5851, 5852, 5861 or 5862) one service must be from the Partial Hospitalization and Intensive Outpatient Primary list. The commenters stated that the requirement of a primary service may undermine the flexibility to provide the full scope of services within IOP. Commenters suggested CMS review utilization data to determine which services should be added or removed from the Partial Hospitalization and Intensive Outpatient Primary Services list.

Response: While we appreciate commenters' input, we disagree that requiring one service from the Partial Hospitalization and Intensive Outpatient Primary list in order to qualify for payment for under IOP may undermine the flexibility to provide the full scope of services. To ensure program integrity, we expect that at least one of the services on the Partial Hospitalization and Intensive Outpatient Primary list will be indicated per day for patients who need the level of care offered by a PHP or IOP program.

Final Decision: After consideration of the public comments we received, we are finalizing our proposal to add code 90853 Group psychotherapy, as well as to maintain G0410 and G0411 on the list of HCPCS codes applicable to PHP and IOP, as well as to add additional codes describing a service already enumerated at § 410.43(a)(4) or § 410.44(a)(4) through a sub-regulatory process.

Further, we are finalizing that at least one service must be from the Partial Hospitalization and Intensive Outpatient Primary Services list to qualify for payment for the PHP or IOP APC. The final list of Partial Hospitalization and Intensive Outpatient Primary Services is found in table 99 of this final rule with comment period.

3. Additional HCPCS Codes Considered for CY 2024 in Response to Comments

As we noted in the prior section, we solicited comment in the CY 2024 OPPS/ASC proposed rule on any additional codes that we should consider adding to the list of HCPCS Applicable for PHP and IOP. Specifically, we stated that we were interested in hearing from commenters if there are any other existing codes that CMS should consider adding to the list, or new codes that CMS should consider creating, to describe specific services not appropriately described by the codes shown in Table 96 of this final rule with comment period.

We provided some examples of such services for public consideration and comment, including caregiver-focused services, services of peer support specialists, and services related to discharge planning and care coordination. In addition, commenters suggested additional services for consideration, as discussed in the following sections.

a. Caregiver-Focused Services

In the proposed rule, we explained that we were particularly interested in whether it would be appropriate to include caregiver-focused services in the list of recognized services for PHP and IOP. We identified and solicited comment on including the following HCPCS codes describing services related to caregivers:

- 96202 multiple -family group behavior management/modification training for parents(s) guardians(s) caregivers(s) with a mental or physical health diagnosis, administered by a physician or other QHP without the patient present, face to face up to 60 minutes.
- 96203 each additional 15 minutes.
- 96161 administration of caregiver-focused health risk assessment instrument (that is, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.
- 9X015 CAREGIVER TRAINING 1ST 30 MIN
- 9X016 CAREGIVER TRAINING EA ADDL 15
- 9X017 GROUP CAREGIVER TRAINING

We noted that the CMHC conditions of participation at § 485.916(b) and (c) already include references to the role of caregivers in the development and implementation of the individualized treatment plan for PHP patients, and we referred readers to section XVII.B.4 of the CY 2024 OPPS/ASC proposed rule for discussion of proposed amendments to the regulations at § 485.916(d). We solicited comments on whether it would be appropriate to include costs for such services in the calculation of PHP and IOP per diem payment rates. We noted that if we were to include such services, we believe it would be appropriate to exclude them from the determination of the number of services provided per day, but we could include such services in the calculation of cost per day for determining the PHP and IOP payment rates.

Comment: Many commenters supported the inclusion of caregiver-focused services, such as codes 96202, 96203, 96161, 9X015, 9X016, and 9X017, in the list of recognized services for PHP and IOP. A majority of commenters advocated for both including caregiver-focused services in the cost per day and in the determination of the number of services provided per day. One commenter supported including caregiver-focused services in the cost per day but excluding them from the determination of number of services provided per day.

Response: In light of commenters' input, we are adopting the identified codes for caregiver-focused services in the final consolidated list of HCPCs codes recognized for PHP and IOP. We note that placeholder codes 9X015, 9X016, and 9X017 have been replaced with CPT codes 97550, 97551, and 97552 respectively. We believe that including caregiver services as covered under the PHP and IOP benefits supports the directive to consider family caregivers across policies and programs under the Executive Order on Increasing

Access to High-Quality Care and Supporting Caregivers.[163]

We believe that these services can be appropriately considered patient training and education services under §§ 410.43(a)(4)(vii) and 410.44(a)(4)(vii), and therefore we are not making any changes to the conditions and exclusions for PHP or IOP in adopting these codes. When these codes are reported, they will not count toward payment for a 3-service or 4-service day; however, we will include the costs associated with providing such services when calculating the PHP and IOP payment rates in future years.

b. Discharge and Transition Planning

In addition, we solicited comments on whether it would be appropriate to add services related to coordinating a patient's discharge from a PHP or IOP, or their transition from one level of care to another. We note that current regulations require physicians, hospitals, and CMHCs to address discharge planning for PHP patients, and we proposed the same requirements for IOP patients. Specifically, physician recertification requirements for PHP at § 424.24(e)(3)(iii)(C) state that the physician's recertification must address treatment goals for coordination of services to facilitate discharge from the partial hospitalization program. We noted that we proposed the same requirement for IOP at § 424.24(d)(3)(iii)(C), which we are finalizing in this final rule. Additionally, hospital CoPs at § 482.43, which apply to hospital outpatient departments providing PHP and IOP, and CMHC CoPs at § 485.914(e), require appropriate discharge planning to meet each patient's needs. We solicited comments on whether the proposed codes shown in Table 96 of this final rule with comment period represent the services that PHPs and IOPs provide to support transition and discharge planning for their patients, or whether we should consider additional codes. We asked commenters to provide as much detail as possible about the nature of any additional services, and whether there are any existing codes that could describe such services.

Comment: Commenters supported the inclusion of services related to discharge and transition between one level of care to another. Specifically, commenters suggested codes for discharge-related services, care coordination, and case management services, such as 99484 (Coordinated care services/care coordination). One commenter suggested codes 99424–99427 (Principal care management services), 99437 and 99439 (Chronic care management services), and 99489–99491 (Complex chronic care management services). Commenters stated these services are especially important for patients with co-occurring conditions that are being treated in multiple settings simultaneously. Several commenters recommended that CMS recognize proposed coding for Principal Illness Navigation (PIN), social determinants of health (SDOH) risk assessment, and community health integration (CHI) under the Physician Fee Schedule as PHP and IOP codes.

Response: We thank commenters for their suggestions to consider adopting PIN, CHI, and SDOH risk assessment codes, which are described in the CY 2024 Physician Fee Schedule proposed rule (88 FR 52325 through 52336), for inclusion in the list of PHP and IOP codes. As discussed in the CY 2024 PFS proposed rule (88 FR 52325), the proposed PIN, CHI, and SDOH risk assessment codes are intended to better identify and value practitioners' work when they incur additional time and resources helping patients with serious illnesses navigate the healthcare system or removing health-related social barriers that are interfering with the practitioner's ability to execute a medically necessary plan of care.

CMS proposed the following descriptions for CHI codes:

GXXX1 Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner; 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting ability to diagnose or treat problem(s) addressed in an initiating E/M visit:

- *Person-centered assessment, performed to better understand the individualized context of the intersection between the SDOH need(s) and the problem(s) addressed in the initiating E/M visit.*

++ *Conducting a person-centered assessment to understand patient's life story, strengths, needs, goals, preferences and desired outcomes, including understanding cultural and linguistic factors.*

++ *Facilitating patient-driven goalsetting and establishing an action plan.*

++ *Providing tailored support to the patient as needed to accomplish the practitioner's treatment plan.*

- *Practitioner, Home-, and Community-Based Care Coordination.*

++ *Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; and from home- and community-based service providers, social service providers, and caregiver (if applicable).*

++ *Communication with practitioners, home- and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.*

++ *Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.*

++ *Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) to address the SDOH need(s).*

- *Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, and preferences, in the context of the SDOH need(s), and educating the patient on how to best participate in medical decision-making.*

- *Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services addressing the SDOH need(s), in ways that are more likely to promote personalized and effective diagnosis or treatment.*

- *Health care access/health system navigation*

++ *Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care and helping secure appointments with them.*

- *Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.*

- *Facilitating and providing social and emotional support to help the patient cope with the problem(s) addressed in the initiating visit, the SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.*

[163] *https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/18/executive-order-on-increasing-access-to-high-quality-care-and-supporting-caregivers/.*

• *Leveraging lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.*

GXXX2—Community health integration services, each additional 30 minutes per calendar month (List separately in addition to GXXX1).

CMS proposed the following description for PIN codes:

GXXX3 Principal Illness Navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator or certified peer specialist; 60 minutes per calendar month, in the following activities:

• *Person-centered assessment, performed to better understand the individual context of the serious, high-risk condition.*

++ Conducting a person-centered assessment to understand the patient's life story, strengths, needs, goals, preferences, and desired outcomes, including understanding cultural and linguistic factors.

++ Facilitating patient-driven goal setting and establishing an action plan.

++ Providing tailored support as needed to accomplish the practitioner's treatment plan.

• *Identifying or referring patient (and caregiver or family, if applicable) to appropriate supportive services.*

• *Practitioner, Home, and Community-Based Care Coordination*

++ Coordinating receipt of needed services from healthcare practitioners, providers, and facilities; home- and community-based service providers; and caregiver (if applicable).

++ Communication with practitioners, home-, and community-based service providers, hospitals, and skilled nursing facilities (or other health care facilities) regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors.

++ Coordination of care transitions between and among health care practitioners and settings, including transitions involving referral to other clinicians; follow-up after an emergency department visit; or follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.

++ Facilitating access to community-based social services (e.g., housing, utilities, transportation, food assistance) as needed to address SDOH need(s).

• *Health education—Helping the patient contextualize health education provided by the patient's treatment team with the patient's individual needs, goals, preferences, and SDOH need(s), and educating the patient (and caregiver if applicable) on how to best participate in medical decision-making.*

• *Building patient self-advocacy skills, so that the patient can interact with members of the health care team and related community-based services (as needed), in ways that are more likely to promote personalized and effective treatment of their condition.*

• *Health care access/health system navigation.*

++ Helping the patient access healthcare, including identifying appropriate practitioners or providers for clinical care, and helping secure appointments with them.

++ Providing the patient with information/resources to consider participation in clinical trials or clinical research as applicable.

• *Facilitating behavioral change as necessary for meeting diagnosis and treatment goals, including promoting patient motivation to participate in care and reach person-centered diagnosis or treatment goals.*

• *Facilitating and providing social and emotional support to help the patient cope with the condition, SDOH need(s), and adjust daily routines to better meet diagnosis and treatment goals.*

• *Leverage knowledge of the serious, high-risk condition and/or lived experience when applicable to provide support, mentorship, or inspiration to meet treatment goals.*

GXXX4—Principal Illness Navigation services, additional 30 minutes per calendar month (List separately in addition to GXXX3).

CMS proposed the following description for SDOH risk assessment:

GXXX5, Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5–15 minutes, not more often than every 6 months

We note that placeholder codes GXXX1 and GXXX2 have been replaced with GCPCS codes G0019 and G0022, respectively; placeholder codes GXXX3 and GXXX4 have been replaced with HCPCS codes G0023 and G0024 respectively; and placeholder code GXXX5 has been replaced with HCPCS code G0136.

As described above, all of these proposed codes include activities related to addressing social needs. Both PIN and CHI include certain care coordination activities and care transitions for the patient. However, there are distinct differences in the primary focus of PIN and CHI codes. As discussed in the CY 2024 PFS proposed rule (88 FR 52334), CMS proposed that in order to bill for PIN, time spent providing such services must be documented in the medical record in its relationship to the serious, high-risk illness. On the other hand, in the case of CHI services, CMS proposed that time spent providing such services must be documented in the patient's medical record in its relationship to the SDOH need(s) they are intended to address and the clinical problem(s) they are intended to help resolve (88 FR 52329).

As discussed in the CY 2024 Physician Fee Schedule proposed rule (88 FR 52335), CMS proposed that a practitioner could bill separately for other care management services during the same month as PIN or CHI, if time and effort are not counted more than once, requirements to bill the other care management services are met, and the services are medically reasonable and necessary. However, in the case of a patient participating in a PHP or IOP, we anticipate that the time and effort of facility staff in addressing the components of PIN services would generally be duplicative of the time and effort of providing CHI services. Furthermore, because PIN also includes an assessment of and activities related to addressing social needs, we believe that for PHP and IOP patients, the time and effort of facility staff associated with PIN services would generally be duplicative of the time and effort of providing SDOH risk assessment services.

We believe PIN would generally be the most appropriate code for patients participating in a PHP or IOP, because a patient's participation in one of these programs indicates the presence of a serious, high-risk mental health condition (inclusive of SUD). In addition, participation in a PHP or IOP requires certification and periodic recertification of the need for such services by a physician, which we believe is analogous to an initiating visit that is required for PIN services billed under the PFS. Therefore, after consideration of the public comments we received, we are adopting PIN services as applicable for PHP and IOP. We believe the PIN services described by codes G0023, G0024 appropriately describe the broad range of services that PHP and IOP staff provide to program participants each patient month, which include discharge and transition planning, care coordination, and case management services within PHPs and IOPs. We note that as discussed in the CY 2024 PFS final rule, CMS is removing references to peer support specialists from the final descriptions for G0023 and G0024, and is finalizing separate codes that better represent the

scope of practice for peer support specialists.

In addition, we note that these PIN services are reported monthly and represent time spent throughout the month; therefore, we will not count PIN services in the evaluation of whether a PHP or IOP day receives the 3-service or 4-service day for payment; however, we intend to analyze utilization and cost data for these services and consider any payment changes in future rulemaking to better recognize such costs.

We are not adopting SDOH risk assessment or CHI services described by G0136, G0019, and G0022 because we believe the inclusion of these codes would likely be duplicative of PIN services for a patient participating in a PHP or IOP. With respect to the principal care management, chronic care management, and complex chronic care management services that commenters suggested, we discussed these recommendations with CMS medical officers and have determined these services are more appropriate for the primary care setting, rather than a defined program of services like a PHP or IOP.

c. Peer Support Specialists

Additionally, we solicited comments in the proposed rule on peer services, and whether these would be appropriate to include for PHPs and IOPs. Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. Peer support workers typically engage in a wide range of activities, including: advocating for people in recovery; sharing resources and building skills; building community and relationships; leading recovery groups; and mentoring and setting goals.[164] We stated in the CY 2024 OPPS/ASC proposed rule that we were interested in information about any available codes that would appropriately describe such services.

Comment: Commenters strongly supported the inclusion of peer support services in the list of codes recognized for PHP and IOP.

Response: As discussed above, we are adopting coding for PIN services. Additionally, as discussed in the CY 2024 PFS final rule, CMS is finalizing additional PIN codes which describe the set of services that are within the scope of practice of peer support specialists. As shown in Table 98 of this final rule with comment period, we are adopting these codes as applicable for PHP and IOP. We believe it is appropriate to recognize the services of peer support specialists working within the scope of practice for which they are licensed or certified under applicable State law, or meeting the requirements set forth in the CY 2024 PFS final rule if no applicable State requirements exist, as the services of staff trained to work with psychiatric patients, which is included under section 1861(ff)(2)(c) and which we have codified under the PHP benefit at § 410.43(a)(4)(iii) and are finalizing under the IOP benefit at § 410.44(a)(4)(iii) in this final rule.

As we noted above for PIN services, these peer support PIN service codes are reported monthly and represent time spent throughout the month; therefore, we will not count them in the evaluation of whether a PHP or IOP day receives the 3-service or 4-service day for payment; however, we intend to analyze utilization and cost data for these services and consider any payment changes in future rulemaking to better recognize such costs.

d. Testing and Diagnostic Services

We noted in the proposed rule that our analysis of PHP claims showed that the provision of testing and diagnostic services is very low among PHPs, although such services are covered under the PHP benefit. We included testing and diagnostic services in the proposed list of codes shown in Table 96 of this final rule with comment period, and we proposed to cover such services under the IOP benefit as well. We noted that our analysis of non-PHP days with 3 and 4 services, which we believe could represent IOP days in the future, shows a higher provision of testing and diagnostic services than is found among PHP days. We stated that we believe testing and diagnostic services would be included as component services of PHPs and IOPs, and we are interested in information from the public about why PHPs are not more frequently billing for these services. In particular, we welcomed information from commenters about whether there are specific challenges that PHPs face in providing these services, as well as whether there are different codes, other than those shown in Table 96 of this final rule with comment period, that could better describe the testing and diagnostic services that are provided to PHP patients. In addition, we stated that we are interested in understanding whether these services are typically provided by an entity other than the PHP, such as by a referring provider.

Comment: Commenters provided useful information about why PHPs are not more frequently billing for testing and diagnostic services. Specifically, the commenters stated that the vast majority of PHPs and IOPs are generally designed to treat common types of behavioral health issues and typically focus on depression, anxiety, bipolar disorder, and self-harm. Commenters stated that testing and diagnostic services are usually more common in specialty programs such as eating disorders, obsessive-compulsive disorders, anger management, and child/adolescent programs. Additionally, commenters stated that while diagnostic services are covered under the PHP benefit, since PHP is intended for patients who have a mental health diagnosis, patients that are admitted to a PHP typically have a mental health diagnosis from a referring provider.

Response: We appreciate the information that commenters provided regarding testing and diagnostic services. While we recognize that these may not be used in most programs, we note that section 1861(ff)(2)(H) specifically includes diagnostic services in the definition of partial hospitalization and intensive outpatient services. We continue to believe it is appropriate to include these codes in the available PHP and IOP code set for those programs that do provide these services. We intend to monitor the provision of these services for PHP and IOP patients and may consider coding changes in the future.

e. Other Categories of Services

Comment: One commenter suggested including a variety of codes commonly billed for occupational therapy. For example, codes 97165–97167 for low, moderate, and high complexity occupational therapy evaluations; and code 97168 Occupational therapy re-evaluation.

Response: We appreciate the commenter's recommendation to adopt more detailed coding for occupational therapy. We note that occupational therapy services are an important part of PHPs, specifically listed under 1861(ff)(2)(B) and § 410.43(a)(4)(ii). We also proposed to include occupational therapy services under § 410.44(a)(4). We proposed to include G0129, which is the currently recognized code for

[164] *https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers.*

occupational therapy services provided for PHP patients, and we proposed to recognize this code for IOP patients beginning in CY 2024 as well. We are not including the more detailed list of CPT codes that the commenter recommended; however, we will take this comment into consideration to potentially inform future rulemaking.

Comment: Commenters suggested adding SUD screening and diagnostic evaluations (including G0396 and G0397), GXXX5 Social determinants of health assessment, and individual and group SUD counseling. Additionally, commenters suggested including codes 99446–99449 Interprofessional phone/internet/electronic health record consultation services, as well as withdrawal management, medication management, and psychoeducation services. One commenter advocated the creation of a new add-on code for psychoeducation services.

Response: After consideration of the public comments received, we do not believe SUD screening and diagnostic evaluations, social determinants of health assessment, individual and group SUD counseling, withdrawal management, medication management, or psychoeducation services are appropriate for the PHP or IOP benefits. We consulted with physicians and have determined these services are typically provided by a primary care provider for screening purposes.

Comment: A few commenters suggested including transportation and meals.

Response: While we appreciate the commenters' input, we remind readers that section 1861(ff)(2)(I) of the Act excludes transportation and meals from the items and services that may be offered provided under the PHP and IOP benefits.

Final Decision: After consideration of the public comments we received, we are adopting as final the following list of PHP and IOP codes for CY 2024, which is presented in Table 98.

BILLING CODE 4150–28–P

TABLE 98: FINAL HCPCS APPLICABLE FOR PHP AND IOP

HCPCS/CPT	Short Descriptor	Final Action
90785	Psytx complex interactive	
90791	Psych diagnostic evaluation	
90792	Psych diag eval w/med srvcs	
90832	Psytx pt&/family 30 minutes	
90833	Psytx pt&/fam w/e&m 30 min	
90834	Psytx pt&/family 45 minutes	
90836	Psytx pt&/fam w/e&m 45 min	
90837	Psytx pt&/family 60 minutes	
90838	Psytx pt&/fam w/e&m 60 min	
90839	Psytx crisis initial 60 min	Add
90840	Psytx crisis ea addl 30 min	Add
90845	Psychoanalysis	
90846	Family psytx w/o patient	
90847	Family psytx w/patient	
90849	Multiple family group psytx	Add
90853	Group psychotherapy	Add
90865	Narcosynthesis	Remove
90880	Hypnotherapy	
90899	Psychiatric service/therapy	Add
96112	Devel tst phys/qhp 1st hr	Add
96116	Neurobehavioral status exam	
96130	Psychological testing evaluation by physician/qualified health care professional; first hour	
96131	Psychological testing evaluation by physician/qualified health care professional; each additional hour	
96132	Neuropsychological testing evaluation by physician/qualified health care professional; first hour	
96133	Neuropsychological testing evaluation by physician/qualified health care professional; each additional hour	
96136	Psychological/neuropsychological testing by physician/qualified health care professional; first 30 minutes	
96137	Psychological/neuropsychological testing by physician/qualified health care professional; each additional 30 minutes	
96138	Psychological/neuropsychological testing by technician; first 30 minutes	
96139	Psychological/neuropsychological testing by technician; each additional 30 minutes	
96146	Psychological/neuropsychological testing; automated result only	
96156	Hlth bhv assmt/reassessment	Add
96158	Hlth bhv ivntj indiv 1st 30	Add
96161	Admin of caregiver-focused hlth risk assmt for ben of patient	Add
96164	Hlth bhv ivntj grp 1st 30	Add
96167	Hlth bhv ivntj fam 1st 30	Add

96202	Multiple-family group behavior management/modification training for parent(s) guardian(s) caregiver(s) with a mental or physical health diagnosis up to 60 minutes	Add
96203	Multiple-family group behavior management/modification training for parent(s) guardian(s) caregiver(s) with a mental or physical health diagnosis each addtl 15 minutes	Add
97151	Bhv id assmt by phys/qhp	Add
97152	Bhv id suprt assmt by 1 tech	Add
97153	Adaptive behavior tx by tech	Add
97154	Grp adapt bhv tx by tech	Add
97155	Adapt behavior tx phys/qhp	Add
97156	Fam adapt bhv tx gdn phy/qhp	Add
97157	Mult fam adapt bhv tx gdn	Add
97158	Grp adapt bhv tx by phy/qhp	Add
97550	Caregiver training 1st 30 min	Add
97551	Caregiver training ea addl 15	Add
97552	Grp caregiver training	Add
G0023	Navigate srv 60 min per m	Add
G0024	Navigate srv add 30 min per m	Add
G0129	PHP/IOP OT service	Update
G0140	Nav srv peer sup 60 min pr m	Add
G0146	Nav srv peer sup add 30 pr m	Add
G0176	Opps/php/IOP; activity thrpy	Update
G0177	Opps/php/IOP; train & educ	Update
G0410	Grp psych PHP/IOP 45-50	Update
G0411	Interactive grp psyc PHP/IOP	Update
G0451	Development test interpt&rep	Add

TABLE 99: FINAL PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT PRIMARY SERVICES

HCPCS/CPT	Short Descriptor	Final Action
90832	Psytx pt&/family 30 minutes	
90834	Psytx pt&/family 45 minutes	
90837	Psytx pt&/family 60 minutes	
90845	Psychoanalysis	Add
90846	Family psytx w/o patient	
90847	Family psytx w/patient	
90853	Group psychotherapy	Add
90865	Narcosynthesis	Remove
90880	Hypnotherapy	
96112	Devel tst phys/qhp 1st hr	Add
96116	Neurobehavioral status exam	Add
96130	Psychological testing evaluation by physician/qualified health care professional; first hour	Add
96132	Neuropsychological testing evaluation by physician/qualified health care professional; first hour	Add
96136	Psychological/neuropsychological testing by physician/qualified health care professional; first 30 minutes	Add
96138	Psychological/neuropsychological testing by technician; first 30 minutes	Add
G0410	Grp psych partial hosp/IOP 45-50	Update
G0411	Inter active grp psych PHP/IOP	Update

BILLING CODE 4150–28–P

D. Payment Rate Methodology for PHP and IOP

In summary, we proposed for CY 2024 to revise our methodology for calculating PHP payment rates. We proposed to establish four separate PHP APC per diem payment rates: one for CMHCs for 3-service days and another for CMHCs for 4-service days (APC 5853 and APC 5854, respectively), and one for hospital-based PHPs for 3-service days and another for hospital-based PHPs for 4-service days (APC 5863 and APC 5864, respectively). In addition, for hospital-based PHPs, we proposed to calculate payment rates using the broader OPPS data set, instead of hospital-based PHP data only, because we believe using the broader OPPS data set would allow CMS to capture data from claims not identified as PHP, but that also include the service codes and intensity required for a PHP day. Because we proposed to establish consistent coding and payment between the PHP and IOP benefits, we proposed to consider all OPPS data for PHP days and non-PHP days that include 3 or more of the same service codes. We proposed to establish four separate IOP APC per diem payment rates at the same rates we proposed for PHP APCs: one for CMHCs for 3-service days and another for CMHCs for 4-service days (APC 5851 and APC 5852, respectively), and one for hospital-based IOPs for 3-service days and another for hospital-based IOPs for 4-service days (APC 5861 and APC 5862, respectively). We received public comments on these proposals, which we discuss and provide responses to in the following sections of this CY 2024 OPPS/ASC final rule.

1. Background

The standard PHP day is typically four services or more per day. We currently provide payment for three services a day for extenuating circumstances when a beneficiary would be unable to complete a full day of PHP treatment. As we stated in the CY 2008 OPPS/ASC final rule with comment period (72 FR 66672), it was never our intention that days with only three units of service should represent the number of services provided in a typical PHP day. Our intention was to cover days that consisted of three units of service only in certain limited circumstances. For example, as we noted in the CY 2009 OPPS/ASC proposed rule (73 FR 41513), we believe 3-service days may be appropriate when a patient is transitioning towards discharge (or days when a patient who is transitioning at the beginning of his or her PHP stay). Another example of when it may be appropriate for a program to provide only three units of service in a day is when a patient is

required to leave the PHP early for the day due to an unexpected medical appointment.

2. Current Payment Rate Methodology for PHP

Since CY 2017, our longstanding policy has been to pay PHP on a per diem basis for days that include three or more PHP services, which are identified using a defined list of codes in the Healthcare Common Procedure Coding System (HCPCS). We currently (for CY 2023) utilize two separate PHP APC per diem payment rates: CMHC PHP APC 5853 (Partial Hospitalization (three or More Services Per Day)) using only CMHC data, and hospital-based PHP APC 8563 (Partial Hospitalization (three or More Services Per Day)) using only hospital-based PHP data.

Under longstanding OPPS policy, the hospital-based PHP APC per diem payment amount is also applied as a daily mental health cap, which serves as an upper limit on payment per day for individual OPPS mental health services. Under the current methodology, for CY 2023, hospital-based PHPs are paid a per diem rate of $268.22 for three or more PHP services per day, and CMHCs are paid a per diem rate of $142.70 for three or more PHP services per day. We refer readers to the PHP ratesetting methodology described in section VIII.B.2 of the CY 2016 OPPS/ASC final rule with comment period (80 FR 70462 through 70466) for information on the current calculation of geometric mean per diem costs and payment rates for PHP APCs 5853 and 5863, and the CY 2017 OPPS/ASC final rule with comment period (81 FR 79680 through 79687) and the CY 2022 OPPS/ASC final rule with comment period (86 FR 63665 and 63666) for information on modifications incorporated into the PHP ratesetting methodology.

We note that under our current methodology, we have historically prepared the data by first applying PHP-specific trims and data exclusions and assessing CCRs. We direct the reader to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70463 through 70465) for a more complete discussion of these trims, data exclusions, and CCR adjustments. In prior rules, we have typically included a discussion of PHP-specific data trims, exclusions, and CCR adjustments; we are not including that discussion in this rule. These PHP-specific data trims and exclusions addressed limitations as well as anomalies in the PHP data. However, as discussed in the following section, we proposed for CY 2024 to calculate hospital-based PHP payment rates for 3 services per day and 4 services per day based on cost per day using the broader OPPS data set. Accordingly, we proposed not to apply PHP-specific trims and data exclusions, but rather to apply the same trims and data exclusions consistent with the OPPS.

We did not receive any public comments regarding the proposal, and we are finalizing it as proposed. Additional information about the data trims, data exclusions, and CCR adjustments applicable to the data used for this final rule can be found online at *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html*).[165]

3. CY 2024 Payment Rate Methodology for PHP and IOP

As we noted in the proposed rule, the CAA, 2023 established IOP within the continuum of care, and the statute makes reference to weekly hour requirements. Specifically, IOP patients are required to be certified by a physician as needing at least 9 hours of services per week; while PHP patients are required to be certified by a physician as needing at least 20 hours of services per week.

We stated in the proposed rule that while no IOP benefit existed prior to the CAA, 2023, the types of items and services included in IOP have been, and are, paid for by Medicare either as part of the PHP benefit or under the OPPS more generally. Additionally, we stated that prior to the CAA, 2023, CMS had begun gathering information from interested parties on IOP under Medicare. In the CY 2023 OPPS/ASC proposed rule (87 FR 44679), we issued a comment solicitation on intensive outpatient mental health treatment, including SUD treatment furnished by IOPs, to collect information regarding whether there are any gaps in coding that may be limiting access to needed levels of care for treatment of mental health disorders or SUDs for Medicare beneficiaries, and specific information about IOP services, such as the settings of care in which these programs typically furnish services, the range of services typically offered, and the range of practitioner types that typically furnish these services.

We explained that along with the requirements for IOP mandated by the CAA, 2023, we took into consideration information we received from the comment solicitation to construct an appropriate data set to develop proposed rates for IOP. Since IOPs furnish the same types of services as PHP, just at a lower intensity, we stated that we believe it is appropriate to use the same data and methodology for calculating payment rates for both PHP and IOP for CY 2024. We explained that although PHP claims can be specifically identified, there is no specific identifier or billing code to indicate IOP services. However, we noted that hospitals are permitted to furnish and bill for many of these services as outpatient services under the OPPS. Thus, we analyzed a broader set of data that includes both PHP and non-PHP days with 3 or more services in order to calculate proposed payment for PHP services. In order to establish consistent payment between PHP and IOP, we proposed to set IOP payment rates at the same rates as PHP. We stated that the primary goal in developing the proposed payment rate methodology for IOP and PHP services was to pay providers an appropriate amount relative to the patients' needs, and to avoid cost inversion in future years.

For CY 2024, we proposed to calculate hospital-based PHP payment rates for 3 services per day and 4 services per day based on cost per day using the broader OPPS data set, a change from the current methodology of using only PHP data. We stated that we believe using the broader OPPS data set would allow us to capture data from claims that are not identified as PHP, but that include the service codes and intensity required for a PHP day. We stated that the larger data set would expand the sample size to allow for more precise rate calculations. In addition, we proposed to calculate the 3 services per day and 4 services per day PHP rates for CMHCs and hospital-based programs separately.

We also proposed to set payment rates for IOP APCs at amounts equal to the payment rates for PHP APCs. We stated that setting the IOP payment rates equal to the PHP payments would be appropriate because IOP is a newly established benefit, and we do not have definitive data on utilization. However, we explained that both programs utilize the same services, but furnish them at different levels of intensity, with different numbers of services furnished per day and per week, depending on the program. Therefore, we stated that we expect it would be appropriate to pay the same per diem rates for IOP and PHP services unless future data analysis supports calculating rates independently. Table 100 below shows the proposed APCs and the calculated

[165] Click on the link labeled ''CY 2024 OPPS/ASC Notice of Final Rulemaking'', which can be found under the heading ''Hospital Outpatient Prospective Payment System Rulemaking'' and open the claims accounting document link at the bottom of the page, which is labeled ''2024 NFRM OPPS Claims Accounting (PDF)''.

geometric mean per diem costs for the CY 2024 OPPS/ASC proposed rule.

TABLE 100: PROPOSED CY 2024 PHP AND IOP APC GEOMETRIC MEAN PER DIEM COSTS

CY 2024 APC	Group Title	Proposed PHP and IOP APC Geometric Mean Per Diem Costs
5851	Intensive Outpatient (3 services per day) for CMHCs	$97.59
5852	Intensive Outpatient (4 or more services per day) for CMHCs	$153.09
5853	Partial Hospitalization (3 services per day) for CMHCs	$97.59
5854	Partial Hospitalization (4 or more services per day) for CMHCs	$153.09
5861	Intensive Outpatient (3 services per day) for hospital-based IOPs	$284.00
5862	Intensive Outpatient (4 or more services per day) for hospital-based IOPs	$368.18
5863	Partial Hospitalization (3 services per day) for hospital-based PHPs	$284.00
5864	Partial Hospitalization (4 or more services per day) for hospital-based PHPs	$368.18

For beneficiaries in a PHP or IOP, we proposed applying the four-service payment rate (that is, payment for PHP APCs 5854 for CMHCs and 5864 for hospitals, and IOP APCs 5852 for CMHCs and 5862 for hospitals) for days with 4 or more services. For days with three or fewer services, we proposed to apply the three-service payment rate (that is, payment for PHP APCs 5853 for CMHCs and 5863 for hospitals, and IOP APCs 5851 for CMHCs and 5861 for hospitals), which we noted would be a departure from our current policy. We explained that under our current policy, we do not make payment for any PHP days with fewer than three services. We stated that we have heard from interested parties that this policy could discourage treatment of PHP patients when, due to extenuating circumstances, they cannot complete a full day. We stated that we believe paying for a day with three or fewer services would allow us to more easily monitor the actual utilization of services, particularly IOP. Specifically, we stated that we believe utilizing the three-service payment rate (that is, payment for PHP APCs 5853 for CMHCs and 5863 for hospitals, and IOP APCs 5851 for CMHCs and 5861 for hospitals) for days with three or fewer service would accommodate occasional instances when a patient is unable to complete a full day of PHP or IOP. We stated that we expect days with fewer than three services would be very infrequent, and that we intend to monitor the provision of these days among providers and individual patients.

Additionally, we proposed that the 3 service per day hospital-based PHP APC per diem payment amount for APC 5863 would also be applied as the daily mental health cap, which serves as the upper limit on payment per day for individual OPPS mental health services. We explained that setting the 3 service per day hospital-based PHP APC per diem payment amount as the daily mental health cap would be appropriate because currently the daily mental health cap is equal to the payment amount for hospital-based PHP APC 5863, which is payment for 3 or more services per day. Therefore, we noted that consistency with the current daily mental health cap would be maintained. Additionally, we stated that PHP is meant to be the most intensive mental health services program, requiring inpatient care if PHP is not received, and the daily mental health cap is not expected to reach such level of intensity. We stated that we believe applying the 3 service per day hospital-based PHP APC per diem payment amount for APC 5863 as the daily mental health cap would preserve the difference of intensity between PHP and individual OPPS mental health services to not incentivize one over the other. We noted that the proposed CY 2024 payment amount for APC 5863 would be comparable to the CY 2023 payment amount for APC 5863, which is currently applied as the daily mental health cap.

Lastly, we noted that section 4124(c) of the CAA, 2023 requires that the payment amount for intensive outpatient services furnished in FQHCs and RHCs be equal to the payment amount that would have been paid for the same service furnished by a hospital outpatient department, thus establishing site-neutral payment for hospital outpatient departments, FQHCs, and RHCs. We explained that the CAA, 2023 is silent with respect to the payment methodology for IOP services provided by CMHCs. Based on our analysis of CMHC costs, we stated that we continue to observe that CMHCs incur significantly different costs than hospitals in the provision of PHP services, and stated that we anticipate in the future there will be significant differences between CMHCs' and hospitals' costs of furnishing IOP services as well. We explained that we believe it is appropriate to continue to recognize the differences in cost structures for different providers of PHP. We further explained that this is of particular importance not only to the Medicare program, but also for the Medicare beneficiaries that CMHCs serve, who incur a 20 percent copay on all PHP services under Part B. Therefore, we proposed to continue calculating CMHC payment rates based solely on CMHC claims. However, we stated that we were also considering whether establishing a site-neutral payment for all providers of IOP using data from all providers of IOP would be more appropriate in an effort to increase access to mental health services. In order to inform public awareness, we calculated combined payment rates for the proposed rule by using the broader OPPS data from both hospitals and CMHCs to estimate the costs associated

with providing days with three and four services from the proposed list of services, which is reproduced in Table 96 of this final rule with comment period. We provided these alternative cost calculations in Table 46 in section VIII.D.3.b of the CY 2024 OPPS/ASC proposed rule. We solicited comments on whether this approach would be more appropriate to consider for establishing payment beginning in CY 2024. Specifically, we stated that we were interested in any information from commenters on how IOPs may structure their service days, and how the differences in cost structures of CMHCs might affect a site-neutral payment for IOP services. We also solicited comments on any ways IOP days could differ from PHP days, and considerations that could affect payment.

We received a number of public comments on these proposals. Our summaries and responses to the comments we received are included in the following paragraphs.

Comment: Overall, commenters expressed support for the proposed methodology of calculating PHP and IOP rates using a broader set of OPPS data. Several commenters expressed support for the proposed payment for intensive outpatient services and the proposed increases to payment rates for partial hospitalization services for CY 2024. One commenter raised concerns that using a broader set of OPPS data may result in inadequate reimbursement for hospital-based PHPs that furnish IOPs, given the additional resource costs associated with these sites of care.

Response: We appreciate the support from commenters. As noted earlier, we proposed to use a broader set of OPPS data in order to capture data from claims that are not identified as PHP, but that include the service codes and intensity required for a PHP day. In general, our analysis finds that non-PHP days furnished in the hospital outpatient setting that include 3 services and 4 or more services generally have comparable costs to PHP days furnished in the hospital setting with a comparable number of services provided. As we have discussed in prior rulemaking (85 FR 86075; 84 FR 61343), data from a small number of providers with low service costs per day have driven fluctuations in PHP payment rates, which has necessitated certain policies to stabilize payment in the past. We believe that using a broader set of OPPS data for days with a similar type and number of services appropriately provides stability for the calculation of PHP and IOP payment rates for CY 2024.

Comment: Commenters strongly supported the proposal to stratify payment for PHP and IOP days into 3-service and 4-service days. Several commenters stated that bifurcating each service into two tiers takes into account the varying levels of need among individuals receiving services. Commenters also strongly supported our proposal to make payment at the applicable 3-service rate for PHP and IOP days with fewer than 3 services. Commenters expressed that this flexibility is particularly important for ensuring that the new IOP benefit is made available to patients.

Response: We appreciate the support for the proposal to stratify payment and to make payment for days with fewer than 3 services. We share the commenters' view that these proposed policies are important for supporting access to the new IOP benefit and appropriately matching payment to daily service intensity for patients participating in both PHPs and IOPs. We are reiterating our expectation that days with fewer than three services should be very infrequent, and we are reminding readers that we intend to monitor the provision of these days among providers and individual patients.

Comment: Commenters generally supported the proposal to calculate the per diem payment rates for IOP based on the proposed per diem payment rates for PHP. As noted earlier in this final rule, several commenters raised concerns that the proposal to pay the same rates for PHP and IOP may be driving the proposed requirement that a service from the ''primary list'' be provided for each day that received payment. These commenters encouraged CMS to revisit this question in future rulemaking as cost and claims data are available, to analyze the key differences between IOP and PHP, including the prevalence of certain services within the bundle.

Response: We appreciate the support from commenters regarding the proposal. As we stated in the proposed rule, we proposed to use the PHP rates, calculated using the broader OPPS data set, as the basis for the proposed CY 2024 IOP rates, because IOP is a newly established benefit for which we do not have definitive data on utilization.

Regarding the statement that the proposed payment policy is the reason for the proposal to require a primary service for each day that receives payment, we are clarifying that this is not the case. As we noted earlier in this CY 2024 OPPS/ASC final rule, the purpose of the primary list is to ensure that IOPs and PHPs are being provided with an appropriate level of intensity to ensure program integrity. Although we expect IOPs to be less intensive than PHPs and to involve fewer weekly hours, we nevertheless expect the services provided to be of an intensity that is commensurate with treating the patient's condition. Because we have proposed to pay IOP on a per diem basis, we believe it is important to ensure a minimum standard of program intensity for each date of service.

Comment: A few commenters expressed support for establishing separate payment rates that recognize the cost differences between hospital outpatient departments and CMHCs. These commenters agreed with CMS that hospitals and CMHCs have different cost structures, and encouraged CMS to finalize payment rates that reflect these differences.

In contrast, several commenters opposed the proposal to establish separate payment rates for hospital outpatient departments and CMHCs, advocating for the alternative combined site-neutral payment rates presented in the proposed rule. These commenters stated that the stark discrepancy in rates between HOPDs and CMHCs for partial hospitalization services may not be representative of these entities' true cost structures. These commenters further noted that the addition of IOP to the Medicare service array may encourage additional facilities around the country to elect to enroll in Medicare as CMHCs. Commenters advocating for site-neutral payment responded to CMS' concerns regarding coinsurance burdens for CMHC patients by stating a large percentage of the low-income patients served by community-based behavioral health providers are dual eligible beneficiaries, for whom Medicaid typically covers Medicare coinsurance costs.

Response: We appreciate the comments we received on this topic. As we noted in the proposed rule, the best available data that we have at this time for assessing the cost of IOP services comes from PHP and OPPS days with similar services provided at the expected intensity level. Current data for partial hospitalization do reflect significant cost structure differences between hospitals and CMHCs, and our longstanding payment policies reflect those differences. We have no factual basis at this time on which to assume, as many commenters suggest, that the stark difference between hospital and CMHC payment rates for PHP services indicate that such services do not reflect the actual cost structure differences between facility types.

We recognize that there is uncertainty about the cost structures of CMHCs that

may in the future enroll in Medicare to provide IOP services. As we noted in the proposed rule, we intend to analyze actual IOP utilization data beginning in CY 2024 to understand the actual structure and costs associated with these programs. We are not adopting the commenter's recommendation to finalize the alternative site neutral payment rates for this CY 2024 OPPS/ASC final rule, but we will take these comments into consideration to potentially inform future rulemaking.

Comment: Interested parties overwhelming advocated for establishing the OPPS daily mental health cap based on proposed APC 5864, rather than APC 5863 as proposed. Commenters stated that this would be consistent with CMS's historical use of the highest PHP per diem payment amount as the basis for the OPPS daily mental health cap.

Response: We appreciate the comments' feedback regarding the proposal. We agree with commenters that the proposed APC 5864 would be the most resource intensive mental health service and would be appropriate to finalize as the basis for the OPPS daily mental health cap in CY 2024. As discussed in section II.A.2.c.(1) of this CY 2024 OPPS/ASC final rule, we are finalizing the use of APC 5864 to establish the payment rate for APC 8010 in CY 2024, rather than using APC 5863 as proposed.

Final Decision: After consideration of the public comments we received, we are finalizing our proposal to establish separate APC per diem payment rates for PHP days with 3 services and 4 or more services and to establish separate APC per diem payment rates for CMHCs and hospital-based PHPs. We are also finalizing our 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, we are finalizing our proposal to make payment at the 3-service rate for PHP or IOP days that have fewer than 3 services.

a. PHP APC Changes and Effects on Geometric Mean Per Diem Costs

For CY 2024 and subsequent years, we are finalizing a revision to our existing methodology to calculate the CMHC and hospital-based PHP geometric mean per diem costs to incorporate the larger data set under the OPPS, including PHP and non-PHP hospital claims for mental health services. We are finalizing our proposal to use the latest available CY 2022 claims data, and CY 2021 cost data. This is consistent with the overall use of cost data for the OPPS, which is discussed in section II.A.1.a. of this final rule with comment period. In addition, we are establishing four separate PHP APC per diem payment rates: two for CMHCs (APC 5853 and APC 5854) and two for hospital-based PHPs (APC 5863 and APC 5864). Following this methodology, we will use the geometric mean per diem cost of $90.02 for CMHCs providing 3-service days (APC 5853), and the geometric mean per diem cost of $161.80 for CMHCs providing 4-service days (APC 5854), as the basis for developing the CY 2024 CMHC PHP APC per diem rates. Additionally, we will use the geometric mean per diem cost of $266.35 for hospital-based providers providing 3-service days (APC 5863), and the geometric mean per diem cost of $367.79 for hospital-based providers providing 4-service days (APC 5864) as the basis for developing the CY 2024 hospital-based PHP APC per diem rates. Lastly, we are establishing four separate IOP APC per diem payment rates: two for CMHCs (APC 5851 and APC 5852 for 3-service days and 4-service days, respectively) and two for hospital-based IOPs (APC 5861 and APC 5862 for 3-service days and 4-service days, respectively) using the same above 3-service day and 4-service day geometric mean per diem costs finalized for the PHP APC per diem rates.

b. Development of the PHP and IOP APC Geometric Mean Per Diem Costs

The types of items and services paid as PHP (and that will be paid as IOP) can also be provided outside of those benefits by hospitals; therefore, we sought to understand the costs of those services in our preliminary analysis to consider options for the proposed payment rates for IOP services. In preparation for this CY 2024 final rule, in collaboration with physicians, we developed a consolidated list of all HCPCS codes that would be appropriate for identifying IOP and PHP services for analytic purposes. We refer readers to section VIII.C of this final rule with comment period for more detailed information on the consolidated list of HCPCS codes applicable for IOP and PHP services.

We calculated the final payment rates for hospital-based providers based on costs for days with three services and days with four services using the data from all OPPS claims for hospitals and calculated the final payment rates for CMHCs based on costs for days with three services and days with four services using only the data from CMHC claims. As discussed in section VIII.B.1.a of the CY 2022 OPPS/ASC final rule with comment period (86 FR 63666 through 63668), the costs for CMHC service days are calculated using cost report information from HCRIS. Although we anticipate that IOP weeks would generally include 9–19 hours of services and PHP weeks would generally include 20 or more hours of services, we did not restrict the data for this analysis by weekly hours. Because IOP is a new benefit, we do not have definitive data on utilization. However, if IOP utilization is similar to the data we analyzed for beneficiary weeks with 9 to 19 hours of mental health services, then we expect that IOP days will mostly include three services or fewer but may sometimes include four or more. Given the uncertainty about how IOPs will structure their service days in the future, we proposed and believe it is appropriate to finalize 3-service day and 4-service day APCs for IOP with payment rates that are the same as the rates for the 3-service day and 4-service day APCs for PHP.

We analyzed all CMHC and hospital claims data under the OPPS used to set final rates for this CY 2024 final rule. We identified all patient days that included three or more services from the list in Table 98. As discussed in section VIII.D.3 of this final rule with comment period, we calculated PHP payment rates for days with three services and days with four or more services, and we utilized these PHP payment rates for the IOP APCs as well. We are finalizing our proposal to calculate separate rates for hospitals and CMHCs.

c. CY 2024 PHP and IOP APC Geometric Mean Per Diem Costs

Following this structure, the final calculated CY 2024 PHP geometric mean per diem cost for all CMHCs for providing 3 services per day is $90.02, which we will use for calculating the payment rate for the 3-service day APC, CMHC APC 5853. The final calculated CY 2024 geometric mean per diem cost for all CMHCs for providing four or more services per day is $161.80, which we will use for calculating the payment rate for the 4-service day APC, CMHC APC 5854. As noted, the calculated CY 2024 hospital-based PHP APC geometric mean per diem cost for hospital-based PHP providers that provide 3 services per service day is $266.35, which we will use for calculating the payment rate for the 3-service day hospital-based PHP APC 5863. The calculated CY 2024 hospital-based PHP APC geometric mean per diem cost for hospital-based PHP providers that provide 4 or more services per day is $367.79, which we will use for calculating the payment rate for the 4-service day hospital-based PHP APC 5864.

Similarly, the calculated CY 2024 IOP geometric mean per diem cost for all

CMHCs for providing 3 services per day is $90.02, which we will use for calculating the payment rate for the 3-service day APC, CMHC APC 5851. The calculated CY 2024 geometric mean per diem cost for all CMHCs for providing 4 or more services per day is $161.80, which we will use for calculating the payment rate for the 4-service day APC, CMHC APC 5852. The calculated CY 2024 hospital-based IOP APC geometric mean per diem cost for hospital-based IOP providers that provide 3 services per service day is $266.35, which we will use for calculating the payment rate for the 3-service day hospital-based IOP APC 5861. The calculated CY 2024 hospital-based IOP APC geometric mean per diem cost for hospital-based IOP providers that provide 4 services per day is $367.79, which we proposed to use for calculating the payment rate for the 4-service day hospital-based IOP APC 5862.

We intend to monitor the provision of services in both PHP and IOP programs to better understand utilization patterns, and we are finalizing our proposal to set equal payment rates for PHP and IOP services until actual IOP utilization data becomes available for CY 2026 ratesetting, at which point we anticipate reevaluating our payment rate methodology if necessary. In addition, we solicited comments on the service mix used to develop the per diem amounts for both PHP and IOP. We stated that we are interested in whether the proposed approach is appropriate, and any feedback commenters have on the service mix provided within each program.

The final CY 2024 PHP geometric mean per diem costs are shown in Table 101 and are used to derive the final CY 2024 PHP APC per diem rates for CMHCs and hospital-based PHPs-. As stated in section VIII.D.3 of this final rule with comment period, we are finalizing our proposal to use the same 3—service day and 4-service day geometric mean per diem PHP costs for the CY 2024 CMHC and hospital-based IOP APCs. The final CY 2024 PHP and IOP APC per diem rates are included in Addendum A to this final rule with comment period (which is available on our website at: *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html*) and in Table 101.

TABLE 101: CY 2024 PHP AND IOP APC GEOMETRIC MEAN PER DIEM COSTS

CY 2024 APC	Group Title	Final PHP and IOP APC Geometric Mean Per Diem Costs
5851	Intensive Outpatient (3 services per day) for CMHCs	$90.02
5852	Intensive Outpatient (4 or more services per day) for CMHCs	$161.80
5853	Partial Hospitalization (3 services per day) for CMHCs	$90.02
5854	Partial Hospitalization (4 or more services per day) for CMHCs	$161.80
5861	Intensive Outpatient (3 services per day) for hospital-based IOPs	$266.35
5862	Intensive Outpatient (4 or more services per day) for hospital-based IOPs	$367.79
5863	Partial Hospitalization (3 services per day) for hospital-based PHPs	$266.35
5864	Partial Hospitalization (4 or more services per day) for hospital-based PHPs	$367.79

E. Outlier Policy for CMHCs

For CY 2024, we proposed to update 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. These topics are discussed in more detail. We refer readers to section II.G.1 of this final rule with comment period for our general policies for hospital outpatient outlier payments.

1. Background

As discussed in the CY 2004 OPPS final rule with comment period (68 FR 63469 through 63470), we noted a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP services. Given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. Therefore, beginning in CY 2004, we created a separate outlier policy specific to the estimated costs and OPPS payments provided to CMHCs. We designated a portion of the estimated OPPS outlier threshold specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS each year, excluding outlier payments, and established a separate outlier threshold for CMHCs. This separate outlier threshold for CMHCs resulted in $1.8 million in outlier payments to CMHCs in CY 2004 and $0.5 million in outlier payments to CMHCs in CY 2005 (82 FR 59381). In contrast, in CY 2003, more than $30 million was paid to CMHCs in outlier payments (82 FR 59381).

2. CMHC Outlier Percentage

In the CY 2018 OPPS/ASC final rule with comment period (82 FR 59267 and 59268), we described the current outlier policy for hospital outpatient payments and CMHCs. We note that we also discussed our outlier policy for CMHCs in more detail in section VIII.C of that same final rule (82 FR 59381). We set our projected target for all OPPS aggregate outlier payments at 1.0 percent of the estimated aggregate total payments under the OPPS (82 FR 59267). This same policy was also reiterated in the CY 2019 OPPS/ASC final rule with comment period (83 FR 58996), the CY 2020 OPPS/ASC final rule with comment period (84 FR 61350), and the CY 2021 OPPS/ASC final rule with comment period (85 FR 86082).

We estimated CMHC per diem payments and outlier payments for this rule by using the most recent available utilization and charges from CMHC claims, updated CCRs, and the proposed payment rates for PHP APCs 5853 and 5854. We recognize that CMHCs would be permitted to provide and bill for IOP beginning in CY 2024 and would be paid under IOP APCs 5851 and 5852. However, we have not included estimates of utilization for these APCs, because the latest available claims from CY 2022 do not reflect the provision of IOP services. For increased transparency, we are providing a more detailed explanation of the existing

calculation process for determining the CMHC outlier percentages. To calculate the CMHC outlier percentage, we follow three steps:

- Step 1: We multiply the OPPS outlier threshold, which is 1.0 percent, by the total estimated OPPS Medicare payments (before outliers) for the prospective year to calculate the estimated total OPPS outlier payments: (0.01 × Estimated Total OPPS Payments) = Estimated Total OPPS Outlier Payments.
- Step 2: We estimate CMHC outlier payments by taking each provider's estimated costs (based on their allowable charges multiplied by the provider's CCR) minus each provider's estimated CMHC outlier multiplier threshold (we refer readers to section VIII.C.3 of the CY 2022 OPPS/ASC proposed rule). That threshold is determined by multiplying the provider's estimated paid days by 3.4 times the total of CMHC PHP APC and CMHC IOP payment rates. If the provider's costs exceed the threshold, we multiply that excess by 50 percent, as described in section VIII.E.3 of this final rule with comment period, to determine the estimated outlier payments for that provider. CMHC outlier payments are capped at 8 percent of the provider's estimated total per diem payments (including the beneficiary's copayment), as described in section VIII.E.5 of this final rule with comment period, so any provider's costs that exceed the CMHC outlier cap will have its payments adjusted downward. After accounting for the CMHC outlier cap, we sum all of the estimated outlier payments to determine the estimated total CMHC outlier payments.

(Each Provider's Estimated Costs − Each Provider's Estimated Multiplier Threshold) = A. If A is greater than 0, then (A × 0.50) = Estimated CMHC Outlier Payment (before cap) = B. If B is greater than (0.08 × Provider's Total Estimated Per Diem Payments), then cap adjusted B = (0.08 × Provider's Total Estimated Per Diem Payments); otherwise, B = B. Sum (B or cap-adjusted-B) for Each Provider = Total CMHC Outlier Payments.

- Step 3: We determine the percentage of all OPPS outlier payments that CMHCs represent by dividing the estimated CMHC outlier payments from Step 2 by the total OPPS outlier payments from Step 1: (Estimated CMHC Outlier Payments/Total OPPS Outlier Payments).

We proposed to continue to calculate the CMHC outlier percentage according to previously established policies. However, beginning in CY 2024, CMHCs will be permitted to provide and bill for intensive outpatient services for Medicare patients. Therefore, we proposed to expand the calculation of the CMHC outlier percentage to include PHP and IOP, because we anticipate that total payments will increase for CMHCs in CY 2024. We proposed to maintain our current methodology for calculating the CMHC outlier percentage, but to apply it to payments for IOP services as well as PHP services beginning in CY 2024. Therefore, based on our CY 2024 payment estimates, including our estimates of both PHP and IOP services, CMHCs are projected to receive 0.01 percent of total hospital outpatient payments in CY 2024, excluding outlier payments. We proposed to designate approximately less than 0.01 percent of the estimated 1.0 percent hospital outpatient outlier threshold for CMHCs. This percentage is based upon the formula given in Step 3.

We did not receive any public comments on our proposal and are finalizing our proposal as proposed.

3. Cutoff Point and Percentage Payment Amount

As described in the CY 2018 OPPS/ASC final rule with comment period (82 FR 59381), our policy has been to pay CMHCs for outliers if the estimated cost of the day exceeds a cutoff point. In CY 2006, we set the cutoff point for outlier payments at 3.4 times the highest CMHC PHP APC payment rate implemented for that calendar year (70 FR 68551). For CY 2018, the highest CMHC PHP APC payment rate was the payment rate for CMHC PHP APC 5853. In addition, in CY 2002, the final OPPS outlier payment percentage for costs above the multiplier threshold was set at 50 percent (66 FR 59889). In CY 2018, we continued to apply the same 50 percent outlier payment percentage that applies to hospitals to CMHCs and continued to use the existing cutoff point (82 FR 59381). Therefore, for CY 2018, we continued to pay for partial hospitalization services that exceeded 3.4 times the CMHC PHP APC payment rate at 50 percent of the amount of CMHC PHP APC geometric mean per diem costs over the cutoff point. For example, for CY 2018, if a CMHC's cost for partial hospitalization services paid under CMHC PHP APC 5853 exceeded 3.4 times the CY 2018 payment rate for CMHC PHP APC 5853, the outlier payment would be calculated as 50 percent of the amount by which the cost exceeds 3.4 times the CY 2018 payment rate for CMHC PHP APC 5853 [0.50 × (CMHC Cost − (3.4 × APC 5853 rate))]. This same policy was also reiterated in the CY 2019 OPPS/ASC final rule with comment period (83 FR 58996 through 58997), CY 2020 OPPS/ASC final rule with comment period (84 FR 61351), the CY 2021 OPPS/ASC final rule with comment period (85 FR 86082 through 86083), the CY 2022 OPPS/ASC final rule with comment period (86 FR 63670), and the CY 2023 OPPS/ASC final rule with comment period (87 FR 72004). For CY 2024, we proposed to continue to pay for partial hospitalization services that exceed 3.4 times the proposed CMHC PHP APC payment rate at 50 percent of the CMHC PHP APC geometric mean per diem costs over the cutoff point. In addition, we proposed to extend this policy to intensive outpatient services. That is, for CY 2024, if a CMHC's cost for partial hospitalization services paid under CMHC PHP APCs 5853 or 5854 exceeds 3.4 times the payment rate for the APC (either CMHC APC 5853 or 5854), the outlier payment would be calculated as: [0.50 × (CMHC cost − (3.4 × (PHP APC payment)))].

Similarly, if a CMHC's cost for intensive outpatient services paid under CMHC IOP APCs 5851 or 5852 exceeds 3.4 times the payment rate for the APC (either CMHC APCs 5851 or 5852), the outlier payment would be calculated as: [0.50 × (CMHC cost − (3.4 × (IOP APC payment)))].

We did not receive any public comments on our proposal and are finalizing our proposed policy as proposed.

4. Outlier Reconciliation

In the CY 2009 OPPS/ASC final rule with comment period (73 FR 68594 through 68599), we established an outlier reconciliation policy to address charging aberrations related to OPPS outlier payments. We addressed vulnerabilities in the OPPS outlier payment system that led to differences between billed charges and charges included in the overall CCR, which are used to estimate cost and would apply to all hospitals and CMHCs paid under the OPPS. We initiated steps to ensure that outlier payments appropriately account for the financial risk when providing an extraordinarily costly and complex service but are only being made for services that legitimately qualify for the additional payment.

For a comprehensive description of outlier reconciliation, we refer readers to the CY 2023 OPPS/ASC and CY 2019 OPPS/ASC final rules with comment period (83 FR 58874 and 58875 and 81 FR 79678 through 79680).

We proposed to continue these policies for partial hospitalization services provided through PHPs for CY 2024. In addition, since CMHCs will be permitted to provide and bill for

intensive outpatient services for Medicare patients we proposed to extend these policies to include intensive outpatient services in order to encompass the full scope of services that CMHCs will be permitted to furnish. The current outlier reconciliation policy requires that providers whose outlier payments meet a specified threshold and whose overall ancillary CCRs change by plus or minus 10 percentage points or more, are subject to outlier reconciliation, pending approval of the CMS Central Office and Regional Office (as established in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68596 through 68599)). We note that the current threshold for outlier reconciliation for hospitals is $500,000, and there is no threshold for CMHCs (that is, all outlier payments are subject to reconciliation for CMHCs whose overall ancillary CCRs change by plus or minus 10 percentage points or more). The policy also includes provisions related to CCRs and to calculating the time value of money for reconciled outlier payments due to or due from Medicare, as detailed in the CY 2009 OPPS/ASC final rule with comment period and in the Medicare Claims Processing Manual (73 FR 68595 through 68599 and Medicare Claims Processing internet Only Manual, Chapter 4, Section 10.7.2 and its subsections, available at: *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf*).

We did not receive any public comments on our proposal and are finalizing our proposed policy as proposed.

5. Outlier Payment Cap

In the CY 2017 OPPS/ASC final rule with comment period, we implemented a CMHC outlier payment cap to be applied at the provider level, such that in any given year, an individual CMHC will receive no more than a set percentage of its CMHC total per diem payments in outlier payments (81 FR 79692 through 79695). Our analysis of CY 2014 claims data found that CMHC outlier payments began to increase similarly to the way they had prior to CY 2004. This was due to inflated cost from three CMHCs that accounted for 98 percent of all CMHC outlier payments that year and received outlier payments that ranged from 104 percent to 713 percent of their total per diem payments. To balance our concern about disadvantaging CMHCs with our interest in protecting the benefit from excessive outlier payments and to mitigate potential inappropriate outlier billing vulnerabilities, we finalized the CMHC outlier payment cap at 8 percent of the CMHC's total per diem payments (81 FR 79694 and 79695) to limit the impact of inflated CMHC charges on outlier payments. This outlier payment cap only affects CMHCs, it does not affect other provider types (that is, hospital-based PHPs), and is in addition to and separate from the current outlier policy and reconciliation policy in effect. In the CY 2020 OPPS/ASC final rule with comment period (84 FR 61351), we finalized a proposal to continue this policy in CY 2020 and subsequent years. We proposed to maintain the 8 percent outlier payment cap for CY 2024 and apply it to both PHP and IOP payments. We note that the 8 percent would be calculated as 8 percent of total per diem PHP and IOP payments for CY 2024. As discussed earlier in this rule, beginning in CY 2024, CMHCs will be permitted to provide and bill for intensive outpatient services for Medicare patients. Therefore, we proposed to expand the calculation of the CMHC outlier cap to include both PHP and IOP, because we anticipate that total payments will increase for CMHCs in CY 2024. Therefore, we proposed to calculate the 8 percent outlier payment cap for each CMHC in a way that would encompass the full scope of services that CMHCs will be permitted to furnish in CY 2024.

We did not receive any public comments on our proposal and therefore, we are finalizing as proposed.

6. Fixed-Dollar Threshold

In the CY 2018 OPPS/ASC final rule with comment period (82 FR 59267 and 59268), for the hospital outpatient outlier payment policy, we set a fixed-dollar threshold in addition to an APC multiplier threshold. Fixed-dollar thresholds are typically used to drive outlier payments for very costly items or services, such as cardiac pacemaker insertions. Currently, for CY 2023, CMHC PHP APC 5853 is the only APC for which CMHCs may receive payment under the OPPS and is for providing a defined set of services that are relatively low cost when compared to other OPPS services. Because of the relatively low cost of CMHC services that are used to comprise the structure of CMHC PHP APC 5853, it is not necessary to also impose a fixed-dollar threshold on CMHCs. Therefore, in the CY 2018 OPPS/ASC final rule with comment period, we did not set a fixed-dollar threshold for CMHC outlier payments (82 FR 59381). This same policy was also reiterated in the CY 2020 OPPS/ASC final rule with comment period (84 FR 61351), the CY 2021 OPPS/ASC final rule with comment period (85 FR 86083), the CY 2022 OPPS/ASC final rule with comment period (86 FR 63508), and the CY 2023 OPPS/ASC final rule with comment period (87 FR 72004). We proposed to continue this policy for CY 2024 and not set a fixed-dollar threshold for the CMHC PHP APCs (5853 or 5854) or IOP APCs (5851 or 5852).

Comment: Several commenters urged CMS to implement a site-neutral payment for CMHCs and hospital-based providers for PHP and IOP services. Commenters stated that a site-neutral payment would eliminate the need for a separate outlier policy for CMHCs.

Response: We disagree with commenters who believe that a site-neutral payment would eliminate the need for a separate outlier policy for CMHCs. As discussed in the CY 2004 OPPS final rule with comment period (68 FR 63469 and 63470), we noted a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP services. Given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. Therefore, beginning in CY 2004, we created a separate outlier policy specific to the estimated costs and OPPS payments provided to CMHCs. We designated a portion of the estimated OPPS outlier threshold specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS each year, excluding outlier payments, and established a separate outlier threshold for CMHCs. Furthermore, to balance our concern about disadvantaging CMHCs with our interest in protecting the benefit from excessive outlier payments and to mitigate potential inappropriate outlier billing vulnerabilities, we finalized the CMHC outlier payment cap at 8 percent of the CMHC's total per diem payments (81 FR 79694 and 79695) to limit the impact of inflated CMHC charges on outlier payments. In conclusion, CMS does not believe payment methodology has any effect on outlier policy.

Final Decision: After consideration of the public comments we received, we are finalizing our proposed policy as proposed.

F. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

1. Background

a. Statutory Background

The Rural Health Clinic Services Act of 1977 (Pub. L. 95–210, December 13, 1977), amended the Act by enacting section 1861(aa) of the Act to extend Medicare and Medicaid entitlement and payment for rural health clinics (RHCs), which are defined as being primarily engaged in furnishing outpatient services by physicians and certain nonphysician practitioners, and for services and supplies incidental to their services. ''Nonphysician practitioners'' included nurse practitioners and physician assistants. (Subsequent legislation extended the definition of covered RHC services to include the services of clinical psychologists, clinical social workers, certified nurse midwives, marriage and family therapist, and mental health counselors). The statutory payment requirements for RHC services are set forth at section 1833(a)(3) of the Act, which states that RHCs are paid reasonable costs, less the amount a provider may charge as described in clause of section 1866(a)(2)(A) of the Act, but in no case may the payment exceed 80 percent of such costs.

Section 1861(aa)(2) of the Social Security Act (42 U.S.C. 1395x(aa)(2)) defines the term ''rural health clinic'', in relevant part, as a facility that is located in an area that is not an urbanized area and in which there are insufficient numbers of needed health care practitioners and is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases. Additionally, the law includes a basic requirement that the facility is primarily engaged in providing health care services furnished by physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers to outpatients.

Section 4161 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508, November 5, 1990) (OBRA 90) established Federally Qualified Health Centers (FQHCs) in 1990 to be effective beginning on October 1, 1991. The law mandated that FQHCs furnish services that are typically furnished in an outpatient setting.

Section 1861(aa)(3) of the Act extends Medicare and Medicaid entitlement and payment for those services defined as RHC services under section 1861(aa)(1) of the Act, preventive services defined under section 1861(ddd)(3) of the Act, and preventive primary health services that a center is required to provide under section 330 of the Public Health Service Act furnished at a FQHC. Section 1861(aa)(4) of the Act describes the statutory requirements that FQHCs must meet to qualify for Medicare payment. Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111–148) added section 1834(o) of the Act to establish a new system of payment for the costs of FQHC services under Medicare Part B (Supplemental Medical Insurance) based on prospectively set rates. Section 1834(o)(2)(A) of the Act, the FQHC prospective payment system (PPS) was effective beginning on October 1, 2014. In addition, section 10501(i)(3)(B) of the Affordable Care Act added section 1833(a)(1)(Z) to the Act to specify that Medicare payment for FQHC services under section 1834(o) of the Act shall be 80 percent of the lesser of the actual charge or the amount determined under section 1834(o) of the Act.

Regulations pertaining to RHC and FQHC benefits are codified at 42 CFR part 405, subpart X.

b. Medicare Part B Payment of RHC and FQHC Services

As provided in 42 CFR part 405, subpart X, of our regulations, RHC and FQHC visits generally are face-to-face encounters between a patient and one or more RHC or FQHC practitioners during which one or more RHC or FQHC qualifying services are furnished. RHC and FQHC practitioners are physicians, NPs, PAs, certified nurse-midwife (CNMs), clinical psychologists (CPs), and clinical social workers, and under certain conditions, a registered nurse or licensed practical nurse furnishing care to a homebound RHC or FQHC patient in an area with a shortage of home health agencies. We note, effective January 1, 2024, marriage and family therapist and mental health counselor services are considered RHC services in accordance with section 1861(aa)(1)(B) of the Act as amended by section 4121(b) of CAA, 2023, which is incorporated into FQHC services through section 1861(aa)(3)(A) of the Act. In the CY 2024 PFS proposed rule, we propose to codify payment for MFTs and MHCs at § 405.2411 (88 FR 52398). Only medically necessary medical, mental health, or qualified preventive health services that require the skill level of an RHC or FQHC practitioner are RHC or FQHC billable visits. Services furnished by auxiliary personnel (for example, nurses, medical assistants, or other clinical personnel acting under the supervision of the RHC or FQHC practitioner) are considered incident to the visit and are included in the per-visit payment.

Section 130 of the Consolidated Appropriations Act, 2021 (CAA, 2021) (Pub. L. 116–260, December 27, 2020), updated section 1833(f) of the Act by restructuring the payment limits for RHCs beginning April 1, 2021. As of April 1, 2021, all RHCs are subject to payment limits on the all-inclusive rate (AIR), and this limit will be determined for each RHC in accordance with section 1833(f) of the Act. RHCs generally are paid an AIR for all medically necessary medical and mental health services and qualified preventive health services furnished on the same day (with some exceptions). The AIR is subject to a payment limit, meaning that an RHC will not receive any payment beyond the specified limit amount.

FQHCs were paid under the same AIR methodology until October 1, 2014. Subsequently, FQHCs began to transition to the FQHC PPS system, in which they are paid based on the lesser of the FQHC PPS rate or their actual charges. The FQHC PPS rate is adjusted for geographic differences in the cost of services by the FQHC PPS geographic adjustment factor (GAF). The rate is increased by 34 percent when an FQHC furnishes care to a patient that is new to the FQHC, or to a beneficiary receiving an initial preventive physical examination (IPPE) or has an annual wellness visit (AWV).

Both the RHC AIR and FQHC PPS payment rates were designed to reflect the cost of all services and supplies that an RHC or FQHC furnishes to a patient in a single day. The rates are not adjusted for the complexity of the patient health care needs, the length of the visit, or the number or type of practitioners involved in the patient's care. RHCs and FQHCs are required to file a cost report annually to determine their payment rate, which reflects adjustments for GME payments, bad debt, and influenza, pneumococcal and COVID–19 vaccines and covered monoclonal antibody products used as pre-exposure prophylaxis prevention of COVID–19 and their administration.

There are additional payments for non-face-to-face services for care management services including chronic care management (CCM), principal care management (PCM), chronic pain management (CPM), general behavior health integration (GBHI), psychiatric collaborative care model (CoCM), and virtual communications (§ 405.2464(c)).

Additionally, for FQHCs, § 405.2462(d) describes a ''grandfathered tribal FQHC'' as a FQHC that is operated by a tribe or tribal organization under the Indian Self-

Determination and Education Assistance Act (ISDEAA); was billing as if it were a provider-based to an Indian Health Service (IHS) hospital on or before April 7, 2000, and is not currently operating as a provider-based department of an IHS hospital. We refer to these tribal FQHCs as ''grandfathered tribal FQHCs'' to distinguish them from freestanding tribal FQHCs that are currently being paid the lesser of their charges or the adjusted national FQHC PPS rate, and from provider-based tribal clinics that may have begun operations subsequent to April 7, 2000.

Under the authority in section 1834(o) of the Act to include adjustments determined appropriate by the Secretary, we revised §§ 405.2462 and 405.2464 to pay these grandfathered tribal FQHCs on the Medicare outpatient per visit rate as set annually by the IHS, and not the FQHC PPS payment rates (80 FR 71089). Such payment rates for outpatient medical care (also referred to as outpatient hospital services) furnished by the IHS and tribal facilities is set annually by the IHS under the authority of sections 321(a) and 322(b) of the Public Health Service Act (the PHS Act) (42 U.S.C. 248 and 249(b)) (Pub. L. 83–568 (42 U.S.C. 2001(a)), and the IHCIA, based on the previous year cost reports from Federal and tribal hospitals. The outpatient per visit rate is only applicable for those IHS or tribal facilities that meet the definition of a provider-based department as described at § 413.65(m), or a ''grandfathered'' tribal FQHC as described at § 405.2462(d)(1). There is a higher outpatient per visit rate for IHS and tribal Medicare visits in Alaska and a lower general outpatient per visit rate for IHS/tribal Medicare visits in the lower 48 States (IHS does not operate any hospitals or facilities in Hawaii or the territories, and thus, no rates are set in those localities). For CY 2023, the outpatient per visit rate for Medicare visits in Alaska is $801 and $620 in the lower 48 States.

2. Establishment of Intensive Outpatient Services Benefit by Section 4124 of the CAA, 2023

a. Section 4124 of the Consolidated Appropriations Act of 2023

As we discuss in the CY 2024 OPPS proposed rule (88 FR 49714 and 49715) section 4124 of Division FF of the CAA, 2023 established Medicare coverage for intensive outpatient program (IOP) services furnished by a hospital to its outpatients, or by a community mental health center (CMHC)), a FQHC or a RHC, 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 or residential setting, effective January 1, 2024.

We explained that an IOP is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness, which includes, but is not limited to conditions such as depression, schizophrenia, and substance use disorders. We noted an IOP is thought to be less intensive than a partial hospitalization program (PHP).

This new provision mandated several changes to the RHC and FQHC policies, including scope of benefits and services, certification and plan of care requirements, and special payment rules for IOP services in RHCs and FQHCs, all of which are discussed in the paragraphs below.

3. IOP Scope of Benefits and Scope of Services in RHC and FQHC Settings

a. Background

As described in section 1861(aa) of the Act and codified under §§ 405.2411 and 405.2446, the current scope of benefits for RHC and FQHC services are those services covered in a RHC, FQHC, or other outpatient setting, including a patient's place of residence, or a Medicare-covered Part A skilled nursing facility (SNF) when provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or a clinical social worker. RHC/FQHC services may also be covered for individuals who have elected hospice when provided by an RHC/FQHC physician, nurse practitioner, or physician assistant employed or under contract with the RHC or FQHC at the time the services are furnished, who has been designated by the patient as his or her attending physician. Starting January 1, 2024, services of a marriage and family therapist (MFT) or mental health counselor (MHC) are covered under RHC/FQHC services if such MFT or MHC is employed or under contract with the RHC or FQHC at the time the services are furnished.

As defined in § 405.2415, RHCs and FQHCs furnish physicians' services; services and supplies ''incident to'' the services of physicians: Nurse practitioner (NP), physician assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services; and services and supplies incident to the services of NPs, PAs, CNMs, CPs, and CSWs. They may also furnish diabetes self-management training and medical nutrition therapy (DSMT/MNT), transitional care management (TCM) services, and in some cases, visiting nurse services furnished by a registered professional nurse or a licensed practical nurse.

Only medically necessary medical, mental health, or qualified preventive health services that require the skill level of an RHC or FQHC practitioner are RHC or FQHC billable visits. Services furnished by auxiliary personnel (for example, nurses, medical assistants, or other clinical personnel acting under the supervision of the RHC or FQHC practitioner) are considered incident to the visit and are included in the per-visit payment.

RHC and FQHC services also include certain preventive services when specified in statute or when established through the National Coverage Determination (NCD) process. RHCs and FQHCs are paid for the professional component of allowable preventive services when all of the program requirements are met and frequency limits (where applicable) have not been exceeded.

As discussed in the CY 2024 OPPS proposed rule (88 FR 49715), section 4124(b)(4) of the CAA, 2023, amended section 1861(aa)(1) of the Act by adding subparagraph (D) to establish Medicare Part B coverage for IOP services as defined in section 1861(ff)(4) of the Act when these services are furnished by RHCs, which is incorporated for FQHCs by reference in section 1861(aa)(3)(A) of the Act, effective January 1, 2024. We explained that, section 1861(ff)(2) of the Act describes the items and services available under the PHP and IOP benefits. These items and services include: individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law); occupational therapy requiring the skills of a qualified occupational therapist; services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered); individualized activity therapies that are not primarily recreational or diversionary; family counseling (the primary purpose of which is treatment of the individual's condition); patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment); diagnostic services; and such other items and services as the Secretary may provide (excluding meals and transportation) that are reasonable

and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish, taking into account accepted norms of medical practice and the reasonable expectation of patient improvement.

In the CY 2024 OPPS proposed rule (88 FR 49715), we stated that, in order to be consistent with the scope of benefits required for IOP services under section 1861(ff)(2) of the Act, we proposed to adopt the same standards for IOP services furnished in RHCs and FQHCs as they were proposed for the outpatient hospital setting. For the outpatient hospital setting, we proposed to add regulations at § 410.44 to set forth the conditions and exclusions that would apply for intensive outpatient services (88 FR 49700). Therefore, to be consistent with the statute, we proposed revisions to the RHC and FQHC regulations at 42 CFR part 405, subpart X, that would crosswalk to § 410.44. Specifically, we proposed the following conforming regulatory changes:

- At § 405.2401, Scope and definitions, we proposed to amend the section to add IOP services.
- At § 405.2411, Scope of benefits, we proposed to amend the section to include IOP services.
- At § 405.2446, Scope of services, we proposed to amend this section to include IOP services.

We noted that these proposals would expand access to behavioral health treatment for Medicare beneficiaries and to ensure continuity of care for IOP services to best meet patient needs.

The following is a summary of the public comments received on the scope of benefits for IOP services furnished in RHCs/FQHCs and our responses:

Comment: Many commenters supported our proposal to use the same standards for IOP services furnished in RHCs/FQHCs as in other settings. Commenters stated that these services would expand access to affordable and culturally competent services for the most vulnerable Medicare beneficiaries and hopefully increase rural uptake of this program. One commenter urged CMS to implement these proposals permanently as they will reduce barriers for patients, increase access to crucial services, and improve equity. One commenter encouraged CMS to continue to seek ways to clarify and enhance occupational therapy's role within FQHCs and RHCs. Other commenters urged CMS to provide additional guidance to health centers on classifying professional services furnished by physicians, NPs, PAs, and psychologists during an IOP service.

Response: We appreciate the commenters support. As we noted in the CY 2024 OPPS proposed rule (88 FR 49714) and as discussed in section VIII.B.2 of this final rule with comment period, section 4124 of the CAA, 2023 established Medicare coverage for IOP services to be furnished by FQHCs and RHCs, effective January 1, 2024. Therefore, beginning January 1, 2024, IOP is a permanent benefit that RHCs and FQHCs will be able to furnish in their respective settings.

Regarding occupational therapy's role within RHCs and FQHCs, we note the IOP benefit includes occupational therapy as part of its list of items and services. To reiterate, the types of services covered as intensive outpatient services and the classifications of the types of professional that can provide some of the services include: individual and group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State law; occupational therapy requiring the skills of a qualified occupational therapist, provided by an occupational therapist, or under appropriate supervision of a qualified occupational therapist by an occupational therapy assistant; services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients; drugs and biologicals furnished for therapeutic purposes; individualized activity therapies that are not primarily recreational or diversionary; family counseling, the primary purpose of which is treatment of the individual's condition; patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment; and diagnostic services. CMS is unclear about what the commenter meant by ''classifying professional services,'' but we note that physicians, NPs, PAs, and psychologists are practitioners in FQHCs and as such can furnish IOP services. As with any new benefit under Medicare for RHCs and FQHCs, we will be updating our sub-regulatory guidance and providing outreach and education.

After consideration of the public comments we received, we are finalizing our proposal to adopt the same standards for IOP services furnished in RHCs and FQHCs as in the outpatient hospital and CMHC settings, as proposed. That is, IOP services are services that: (1) are reasonable and necessary for the diagnosis or active treatment of the individual's condition; (2) are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization; (3) are furnished in accordance with a physician certification and plan of care as specified under new regulations at § 424.24(d); and can be individual and group therapy, occupational therapy, drugs and biologicals furnished for therapeutic purposes, which cannot be self-administered, family counseling, beneficiary education, and diagnostic services. Accordingly, we are finalizing our proposal to make conforming regulatory changes to §§ 405.2401, 405.2411, and 405.2446. We note a detailed discussion regarding the final policies under § 410.44 are available in section VIII.B.2 of this final rule with comment period.

b. Certification and Plan of Care Requirements for IOPs in RHC and FQHC Settings

Section 4124(b)(2)(B) of the CAA, 2023 amended section 1861(ff) of the Act to add paragraph (4) to define intensive outpatient services as the items and services prescribed by a physician for an individual determined (not less frequently than once every other month) by a physician to have a need for such services for a minimum of 9 hours per week and provided under a program described in paragraph (3) (that is, an outpatient program of mostly mental health related services and therapies provided by a hospital or CMHC on an outpatient basis) under the supervision of a physician. The services must be provided pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan.

In the CY 2024 OPPS proposed rule (88 FR 49716), we stated to be consistent with physician certification and plan of care requirements required for IOP under section 1861(ff)(4) of the Act, we proposed to adopt the same standards for RHCs and FQHCs as they were proposed for the outpatient hospital setting. For the outpatient hospital setting, we proposed to codify the content of the certification and plan of treatment requirements for intensive outpatient services at § 424.24(d) (88 FR 49702). We explained that physicians would be required to certify that an

individual needs IOP services for a minimum of 9 hours per week and no more than 19 hours per week, as set out in section 4124 of CAA, 2023. This certification would require documentation to include that the individual requires such services for a minimum of 9 hours per week; require the first certification as of the 30th day of IOP services; and require that the certification of IOP services occur no less frequently than every other month. Therefore, to be consistent with the statute, we proposed to revise our regulations at 42 CFR part 405, subpart X, to specify that for the purpose of furnishing IOP services RHCs and FQHCs must similarly meet the certification and plan of care requirements at proposed § 424.24(d).

As discussed in the CY 2024 OPPS proposed rule (88 FR 49716), we also proposed to establish the same patient eligibility criteria for intensive outpatient services as described in proposed § 410.44(c). Specifically, we proposed that intensive outpatient services are intended for patients who: (1) require a minimum of 9 hours per week of therapeutic services as evidenced in their plan of care; (2) are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment; (3) do not require 24-hour care; (4) have an adequate support system while not actively engaged in the program; (5) have a mental health diagnosis; (6) are not judged to be dangerous to self or others; and (7) have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the intensive outpatient program.

The following is a summary of the public comments received on the certification and plan of care requirements for IOP services furnished in RHCs/FQHCs and our responses:

Comment: Commenters were supportive of CMS' proposal to adopt the same standards of physician certification and plan of care requirements for IOP services furnished in RHCs and FQHCs. One commenter recommended that CMS ensure that IOP certification appointments count as FQHC visits by amending the Medicare FQHC-specific payment codes to allow for a physician visit with the purpose of evaluating a patient for IOP (or recertifying the patient) to qualify as a billable mental health ''visit.''

Response: We appreciate the support received from commenters. In response to comments regarding the IOP certification appointments counting as an FQHC visit, we note that medically necessary medical, mental health, or qualified preventive health services that require the skill level of an RHC or FQHC practitioner are RHC or FQHC billable visits. We believe that the physician determination of the need for a patient to receive IOP services, certification for IOP services and recertification would generally be tied to an E/M visit and qualify as an RHC or FQHC billable visit. We believe that the FQHC Specific Payment Code list of qualifying visits under FQHC PPS [166] includes an array of services and appears to capture the type of visit, that is a medical or mental health service that could determine a patient's need for IOP and certification or recertification.

Comment: We received a comment from an RHC association in response to the comment solicitation in the CY 2024 OPPS proposed rule on peer services, and whether these would be appropriate to include for PHPs and IOPs (88 FR 49707). The commenter supports including services that are furnished by a peer support specialist as IOP services. They stated that rural areas are facing a dearth of behavioral health practitioners and oftentimes rely upon professionals with less intensive education and training requirements, like peer support specialists. The commenter further stated that peer support specialists also bring lived experience to their work, which can help them address the unique needs of rural beneficiaries with behavioral health diagnoses and that peer support specialists could be treated similarly to community health workers in CMS' proposed community health integration services.

Response: We thank the commenter for raising this concern. As discussed in section VIII.C of this final rule with comment period, CMS is adopting principal illness navigation (PIN) services as applicable to IOP to be included as IOP services after consideration of the comments received in support of the inclusion of peer support specialist services. Specifically, we discuss the appropriateness of the PIN services described by codes G0023, G0024, G0140, and G0146. Consequently, to the extent that such services are permissible under § 410.44, RHCs and FQHCs could provide them as part of the IOP benefit.

We believe peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. Peer support workers typically engage in a wide range of activities, including: advocating for people in recovery; sharing resources and building skills; building community and relationships; leading recovery groups; and mentoring and setting goals.

With regard to RHCs and FQHCs, we believe that peer support specialists are considered auxiliary personnel, and as such can provide RHC/FQHC services under the direct supervision of the RHC or FQHC practitioner, as long as the peer support specialists are certified or trained to provide all elements in the corresponding service and be authorized to perform them under applicable State law and regulations. A detailed discussion regarding PIN services is available in section II.E of the CY 2024 PFS final rule.

After consideration of the public comments we received, we are finalizing our proposal to adopt the same standards for physician certification and plan of care requirements for RHCs and FQHCs providing IOP services as in the outpatient hospital and CMHC settings. In summary, certification requirements include the physician certifying and documenting that the patient has a need for a minimum of 9 hours of IOP services and must occur at least once every other month.[167] The patient's individualized plan of treatment should address all of the conditions that are being treated by the IOP. Recertification of IOP should occur at least every 60 days.

Accordingly, we are finalizing that for the purpose of furnishing IOP services, RHCs and FQHCs must similarly meet the certification and plan of care requirements at § 424.24(d). This provision is codified in the RHC/FQHC regulations in the final revisions to §§ 405.2401, 405.2411, and 405.2446 by way of the crosswalk to § 410.44 as finalized above in section VIII.B.3. of this final rule with comment period. That is, in § 410.44(a)(3) we have finalized requirements that intensive outpatient services are furnished in

[166] *https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf.*

[167] We note in the CY 2024 OPPS proposed rule (88 FR 49716), we incorrectly summarized the proposed language for § 424.24(d), that is, (1) that the physician must also certify that an individual needs IOP services for no more than 19 hours per week and (2) that it is a requirement for the first certification take place as of the 30th day of IOP services.

accordance with a physician certification and plan of care as specified under § 424.24(d). We note a detailed discussion regarding the final policies under § 424.24(d) are available in section VIII.B.3 of this final rule with comment period.

In addition, we are finalizing the same patient eligibility criteria for intensive outpatient services as described § 410.44(c), as proposed. Specifically, we are finalizing requirements that intensive outpatient services are available for patients who meet the following criteria: (1) require a minimum of 9 hours per week of therapeutic services as evidenced in their plan of care; (2) are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment; (3) do not require 24-hour care; (4) have an adequate support system while not actively engaged in the program; (5) have a mental health diagnosis; (6) are not judged to be dangerous to self or others; and (7) have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the intensive outpatient program. We note a detailed discussion regarding the final policies under § 410.44(c) are available in section VIII.B.2.a. of this final rule with comment period.

4. Special Payment Rules for Intensive Outpatient Services

Under Medicare Part B, payment to RHCs for services (defined in § 405.2411) furnished to beneficiaries is made on the basis of an all-inclusive payment methodology subject to a maximum payment per-visit and annual reconciliation. Our regulations at § 405.2470 provide that RHCs are required to submit cost reports to allow the Medicare Administrative Contractor (MAC) to determine payment in accordance with 42 CFR part 405, subpart X, and instructions issued by CMS. The beneficiary is responsible for the Medicare Part B deductible and coinsurance amounts. Section 1866(a)(2)(A)(ii) of the Act and implementing regulations at § 405.2410(b) establish beneficiary coinsurance at an amount not to exceed 20 percent of the clinic's reasonable charges for covered services.

Under Medicare Part B, FQHCs are paid under the FQHC PPS for services (defined in § 405.2446) furnished to beneficiaries. The statutory payment requirements for FQHC services are set forth at section 1834(o) of the Act. In addition, section 1833(a)(1)(Z) of the Act requires Medicare payment for FQHC services, determined under section 1834(o) of the Act, to be 80 percent of the lesser of the actual charge or the amount determined under section 1834(o) of the Act. Under the FQHC PPS, FQHCs are paid based on the lesser of the FQHC's actual charge for the service or the PPS rate (§ 405.2462(g)(1)). The FQHC PPS rate is subsequently adjusted for certain circumstances as described under § 405.2464(b)(2). The Medicare Part B deductible does not apply to FQHC services. The beneficiary is responsible for a coinsurance amount of 20 percent of the lesser of the FQHC's actual charge for the service or the adjusted PPS rate.

As we discuss in the CY 2021 PFS final rule (85 FR 84699 through 84710), the FQHC PPS base payment is annually increased by the percentage increase in the FQHC market basket, which reflects the operating and capital cost structures for freestanding FQHC facilities. Beginning with CY 2017, FQHC PPS payments were updated using a 2013-based FQHC market basket. A complete discussion of the 2013-based FQHC market basket can be found in the CY 2017 PFS final rule (81 FR 80393 through 80403). In the CY 2021 PFS final rule, we finalized the rebasing and revising of the FQHC market basket to reflect a 2017 base year. The 2017-based FQHC market basket is primarily based on Medicare cost report data for freestanding FQHCs for 2017, which are for cost reporting periods beginning on and after October 1, 2016, and prior to September 31, 2017. We explained that we used data from cost reports beginning in FY 2017 because these data were the latest available, complete data for calculating the major cost weights for the market basket at the time of rulemaking. We also explained that CMS updates the market basket periodically so that the cost weights reflect a current mix of goods and services purchased in providing FQHC services.

Seven FQHCs that have been determined to be grandfathered tribal FQHCs and due to this designation are paid based on the lesser of the outpatient per visit rate or their actual charges, as set out at § 405.2462(f). These grandfathered tribal FQHCs are paid the outpatient per visit rate for furnishing FQHC services.

In addition to the normal package of services, RHCs and FQHCs receive payment for certain additional services. In the CY 2022 PFS final rule (86 FR 65205 and 65206), we implemented section 132 of CAA, 2021, which amended section 1834(o) of the Act and added a new section 1834(y) to the Act, to provide statutory authority for FQHCs and RHCs, respectively, to receive payment for hospice attending physician services. In the CY 2023 PFS final rule (87 FR 69463, 69737 through 69739) we implemented sections 304(b) and (c) of division P of the CAA, 2022 (Pub. L. 117–103, March 15, 2022). Those subsections modified sections 1834(y) and 1834(o)(4) of the Act, respectively, to delay in-person visit requirements in order to for RHCs and FQHCs to receive payment for mental health visits furnished via telecommunications technology.

As we discuss in the CY 2024 OPPS proposed rule (88 FR 49716 and 49717), section 4124(c) of the CAA, 2023 further amended section 1834(o) of the Act and section 1834(y) of the Act, to provide special payment rules for both FQHCs and RHCs, respectively, for furnishing intensive outpatient services. Section 4124(c)(1) of the CAA, 2023 amended section 1834(o) of the Act to add a new paragraph (5)(A) to require that payment for IOP services furnished by FQHCs be equal to the amount that would have been paid under Medicare for IOP services had they been covered outpatient department services furnished by a hospital. In addition, section 4124(c)(2) of the CAA, 2023 amended section 1834(y) of the Act to add a new paragraph (3)(A) to require that payment for IOP services furnished by RHCs be equal to the amount that would have been paid under Medicare for IOP services had they been covered outpatient department services furnished by a hospital.

In the CY 2024 OPPS proposed rule (88 FR 49707 through 49711), we provide a detailed discussion of the proposed CY 2024 payment rate methodology for IOP. We proposed to establish two IOP APC per diem payment rates for hospital-based IOPs (APC 5861 and APC 5862 for 3-service days and 4-service days, respectively).

Consequently, in the CY 2024 OPPS proposed rule (88 FR 49716 and 49717), we addressed our proposed payment policy for RHCs and FQHCs that furnish IOP services. We stated that we believe that it is appropriate to provide a payment structure that supports beneficiaries in an IOP where the utilization is typically structured to be days with three or fewer services. Therefore, we proposed that the rate determined for APC 5861 (Intensive Outpatient (3 services per day) for hospital-based IOPs) would be the payment rate for IOP services furnished in an RHC. For IOP services furnished in FQHCs, we proposed that payment be based on the lesser of a FQHC's actual charges or the rate determined for APC 5861. Additionally, we proposed that grandfathered tribal FQHCs will

continue to have their payment based on the outpatient per visit rate when furnishing IOP services. That is, payment is based on the lesser of a grandfathered tribal FQHC's actual charges or the outpatient per visit rate. We proposed to revise §§ 405.2410, 405.2462, and 405.2464 in the regulations to reflect the payment amount for IOP services and how the Medicare Part B deductible and coinsurance are applied.

In addition, we solicited comment on whether the payment rate for IOP services furnished in RHCs and FQHCs should be adjusted to reflect the variations in costs of furnishing services in different geographic areas and what approaches would be appropriate for determining the value of the adjustment. We also solicited comment on whether the hospital-based IOP APC 5862 for 4-service days would be appropriate for RHCs and FQHCs.

In the CY 2024 OPPS proposed rule (88 FR 49716 and 49717), we discussed the proposals for coding and billing for IOP services under the OPPS. We explained that beginning January 1, 2024, the hospital outpatient department and CMHCs would be able to furnish items and services of both PHPs and IOPs. We stated that we believed it was appropriate to align these programs by using a consolidated list of HCPCS codes would identify the full range of services that both IOPs and PHPs provide to Medicare beneficiaries for billing purposes. We explained that those settings are paid under the OPPS and since they can furnish either PHP or IOP, when submitting a claim to CMS for payment they would be required to report a new condition code 92 to differentiate between PHP and IOP.

We explained that, while RHCs and FQHCs are not authorized to furnish PHP services, we proposed to also require RHCs and FQHCs to report condition code 92 to identify intensive outpatient claims. Since RHCs and FQHCs are paid for IOP services outside of the RHC AIR methodology and FQHC PPS, we believe the condition code reporting approach would allow us to operationalize a 3 service per day payment amount using the final list of HCPCS codes used to identify the full range of services for IOP. In addition, we proposed to align with the requirement under the OPPS, which is in order to qualify for IOP payment, at least one service must be from the Intensive Outpatient Primary list.

We stated, section 4124(c)(1) of the CAA, 2023 amended section 1834(o) of the Act to add a new paragraph (5)(B) to require that costs associated with intensive outpatient services not be used to determine the amount of payment for FQHC services under the FQHC PPS. Likewise, section 4124(c)(2) of the CAA, 2023 amended section 1834(y) of the Act to add a new paragraph (3)(B) to require that costs associated with intensive outpatient services not be used to determine the amount of payment for RHC services under the methodology for all-inclusive rates (established by the Secretary) under section 1833(a)(3) of the Act. Therefore, we proposed conforming revisions under § 405.2468. In addition, we stated conforming revisions would be made to the cost reporting instructions to account for these changes.

We received many comments on our proposals to implement the special payment rule provisions required by section 4124(c)(1) and (2) of the CAA, 2023. The following is a summary of the public comments received on the special payment rules for IOP services furnished in RHCs/FQHCs and our responses:

Comment: Commenters were generally supportive of payment for IOP services furnished by RHCs/FQHCs to be paid outside of the RHC AIR and the FQHC PPS and be paid at the hospital outpatient department (HOPD) rate. Commenters were supportive of CMS' proposal for establishing an IOP APC per diem payment rates for hospital-based IOP for a 3-service day and the use of the condition code for IOP services and agreed with the applicability for RHCs and FQHCs. Commenters also supported CMS' calculation of the IOP payment methodology. Commenters stated that they understood that the statutory language is clear on RHC payment being ''equal to the amount that would have been paid under this title for such services had such services been covered HOPD services furnished by a hospital.''

Response: We appreciate the commenters support on the special payment rules as it relates to payment for IOP services at the HOPD rate.

Comment: One commenter stated that flexibilities granted within this new benefit for other providers should be extended to RHCs as well and asked CMS to allow RHCs to bill for the 3-service day, in the occasional instance when a patient completes three or fewer services in a day, as well.

Response: As we discuss above, in the CY 2024 OPPS proposed rule (88 FR 49717) we proposed to align with the requirement under the OPPS, that in order to qualify for IOP payment, at least one service must be from the Intensive Outpatient Primary list. We note Table 99 of this final rule with comment period identifies the list of intensive outpatient primary services. We believe that this policy is consistent with the commenter's request. In addition, since we otherwise did not receive comment on the proposal, we are finalizing it as proposed. We continue to believe that it is appropriate to provide a payment structure that supports beneficiaries in an IOP where the utilization is typically structured to be days with three or fewer services.

Comment: We received a few comments with respect to CMS' solicitation of comments on whether the hospital-based IOP APC 5862 for 4-service days would be appropriate for RHCs and FQHCs. Several commenters requested that CMS apply the hospital-based IOP rate for 4-service days to RHCs/FQHCs to account for any variations in the cost of furnishing these services in RHCs compared to other settings and geographic areas. One commenter stated that to help address disparities that hinders access to diagnosis and treatment for severe mental illness (SMI), major depressive disorder (MDD), and postpartum depression (PPD) due to severe mental health provider shortages, CMS should finalize an upward variation in the payment rate. The commenter stated that this issue disproportionately impacts rural communities and minorities. Another commenter stated that given IOP is an entirely new benefit and that there is no data on its utilization or cost, CMS should grant broad flexibilities to all providers eligible for the benefit so it can be used as necessary for patients whether three or four separate qualifying IOP services are reported on the claim with condition code 92, the RHC should be eligible to receive the associated payment, $284.00 or $368.18, respectively, similar to how the program will be structured for hospital-based IOPs.

Response: We appreciate feedback in response to our comment solicitation on whether the hospital-based IOP APC 5862 for 4-service days would be appropriate for RHCs and FQHCs. We did not propose the stratified payment rate structure in the initial year of this new benefit for a couple reasons. Section 1861(aa)(2)(K)(iv) of the Act describes an RHC and states that an RHC is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. Given this statutory provision, we believe uptake will be slow since these settings currently focus on primary care service. We believe providing a single payment rate valued at 3 services is adequate in these settings since the expected acuity of the patients are such that they

typically do not need more than 3 services per day.

We do not believe that access would be hindered in these early stages of a new benefit. Considering a week's worth of care which is how the physician certifies the individual, RHCs and FQHCs will be paid each day an IOP service is furnished whether it is 1 or more so in the rare occasion someone is in the clinic and receives 4 services (but is paid for 3), there could be days that week where someone is in the clinic and receives 1 service (but is paid for 3).

Since this is a new program for these settings, we encourage RHCs and FQHCs to report all of the IOP services they furnish on the claim so that we can gather data. We are excited for RHCs and FQHCs to have the opportunity to furnish IOP services and we are interested to see these programs grow. We plan to monitor utilization of IOP services in these and other settings to inform refinements in the future.

Comment: A few commenters requested that CMS clarify that an FQHC's payment amount for IOP services would be the lesser of the FQHC's actual charges for IOP services or the payment amount for a hospital outpatient department providing IOP services.

Response: In response to commenters request that CMS clarify FQHC payment, we refer the commenter to the discussion in the proposed rule (88 FR 49716 and 49717), that the statutory payment requirements for FQHC services are set forth in section 1834(o) of the Act. In addition, section 1833(a)(1)(Z) of the Act requires Medicare payment for FQHC services, determined under section 1834(o) of the Act, to be 80 percent of the lesser of the actual charge or the amount determined under section 1834(o) of the Act.

When we apply this framework, section 1834(o)(5)(A) of the Act as amended by CAA, 2023 requires payment for IOP services furnished by FQHCs be equal to the amount that would have been paid under Medicare for IOP services had they been covered outpatient department services furnished by a hospital. Therefore, this payment amount determined under section 1834(o) of the Act, is subject to the lesser of provisions required under section 1833(a)(1)(Z) of the Act. To clarify, as we finalize above, an FQHC's payment amount for IOP services would be the lesser of the FQHC's actual charges for IOP services or the rate determined for APC 5861.

Comment: With respect to CMS' solicitation of comments on whether the payment rate for IOP services furnished in RHCs/FQHCs should be adjusted to reflect the variations in cost of furnishing services in different geographic areas, one commenter stated that to offer these services, RHCs may need to recruit and retain additional providers and staff or make additional investments in their clinics with associated expenses that may be higher due to their rural locations. The commenter further stated that many RHCs face challenges with reliable broadband connection, limited professional staff, etc. Therefore, they would support a payment adjustment of 5% for rural providers (practicing in areas of 50,000 or less) offering IOP services.

A few commenters did not support a geographic adjustment for reimbursement of IOP services furnished in RHCs because RHC reimbursement methodology for the Original Medicare program does not have a mechanism for applying a geographic adjustment, and adding the geographic adjustment as an additional factor will result in inconsistency and unnecessary complexity. Other commenters stated that they did not believe the application of a geographical adjuster is statutorily required or required by regulation since payment for IOP is not under the FQHC PPS and did not believe a geographical adjuster is necessary for the purposes of payment for IOP services. These commenters urged CMS adopt policies that ensure payments for IOP services are equal, no matter the location of the health center.

Response: We appreciate feedback in response to our comment solicitation on whether the payment rate for IOP services furnished in RHCs and FQHCs should be adjusted to reflect the variations in costs of furnishing services in different geographic areas and what approaches would be appropriate for determining the value of the adjustment and may take this information into consideration for future rulemaking.

Comment: There were a few comments related to billing for IOP services. Some commenters stated that the proposal did not mention whether RHCs/FQHCs will be required to use specific coding (*i.e.,* list each HCPCS code for each discreet service provided in an IOP service day) on IOP claims and think that doing so would be beneficial in that it would improve CMS' access to complete information on the provision of IOP across various settings. Other commenters stated that CMS should clarify if FQHCs should bill for professionals' services (*i.e.,* MD, NPs, PA, and psychologists) via the FQHC PPS or use their Part B enrollment. These commenters believe that health centers should be permitted to allocate the allowable costs like salary, contracting and/or benefits costs associated with these professionals' time under the ''FQHC services'' cost report, if it cannot be included under their IOP cost report. Some commenters requested that CMS provide operational clarifications on how it plans to require FQHCs to bill for IOP services.

Response: We thank the commenters for their questions on billing for IOP services. We agree that specific coding for IOP services will improve CMS access to complete information and provide us with more data with which to monitor IOP services. In response to comments on the use of specific coding on IOP claims, we stated in CY 2024 OPPS proposed rule (88 FR 49717), we proposed to also require RHCs and FQHCs to report condition code 92 to identify intensive outpatient claims. Since RHCs and FQHCs are paid outside of the RHC AIR methodology and FQHC PPS, respectively, for IOP services we believe the condition code reporting approach will allow us to operationalize a 3 service per day payment amount using the final list of HCPCS codes used to identify the full range of services for IOP and therefore we proposed to adopt the same list of services. The list of proposed HCPCS codes is included in Table 96 of this final rule with comment period for reference. In addition, we proposed to align with the requirement under the OPPS, which is in order to qualify for IOP payment, at least one service must be from the Intensive Outpatient Primary list. Table 97 of this final rule with comment period identifies the proposed list of intensive outpatient primary services. Regarding commenters' request for CMS to clarify if FQHCs should bill for professionals' services (*i.e.,* MD, NPs, PA, and psychologists) via the FQHC PPS or use their Part B enrollment, as IOP services are a new benefit for RHCs and FQHCs, the service is billed on the FQHC claim and not on a professional claim using the practitioners Part B enrollment. Therefore, we would like to reiterate that although RHCs and FQHCs are paid outside of the RHC AIR methodology and FQHC PPS, respectively, for IOP services, FQHCs should bill the same way that they currently bill today, that is, on the FQHC claim. We will be issuing sub regulatory guidance and billing instructions related to the RHC and FQHC IOP policies finalized in this final rule as is typically done with any new service.

Comment: One commenter agrees and supports the proposal to pay Grandfathered Tribal FQHCs that furnish IOP services based on the outpatient per visit rate via the IHS AIR.

Response: We appreciate the support received from the commenter.

After consideration of the public comments we received, we are finalizing our proposal to implement the special payment rules for IOP services as proposed. We are finalizing that the rate determined for APC 5861 (Intensive Outpatient (3 services per day) for hospital-based IOPs) is the payment rate for IOP services furnished in an RHC. For IOP services furnished in FQHCs, the payment is based on the lesser of a FQHC's actual charges or the rate determined for APC 5861. Additionally, grandfathered tribal FQHCs will continue to have their payment based on the outpatient per visit rate when furnishing IOP services. That is, payment is based on the lesser of a grandfathered tribal FQHC's actual charges or the outpatient per visit rate. Accordingly, we are finalizing revisions to §§ 405.2410, 405.2462, and 405.2464 in the regulations to reflect the payment amount for IOP services and how the Medicare Part B deductible and coinsurance are applied. Finally, we are finalizing to require RHCs and FQHCs to report condition code 92 to identify intensive outpatient claims. Tables 98 and 99 of this final rule with comment period display the final HCPCS applicable for IOP and the final IOP primary services, respectively.

c. FQHC Supplemental Payments

As discussed in the May 2, 2014 final rule with comment period (79 FR 25461), section 1833(a)(3)(B)(i)(II) of the Act requires that FQHCs that contract with MA organizations be paid at least the same amount they would have received for the same service under the FQHC PPS. This provision ensures FQHCs are paid at least the Medicare amount for FQHC services. Therefore, if the MA organization contract rate is lower than the amount Medicare would otherwise pay for FQHC services, FQHCs that contract with MA organizations would receive a wrap-around payment from Medicare to cover the difference (see § 422.316). If the MA organization contract rate is higher than the amount Medicare would otherwise pay for FQHC services, there is no additional payment from Medicare.

In the CY 2024 OPPS proposed rule (88 FR 49717), we stated that we believe the special payment rule, is also included in the FQHC PPS rate as described in section 1834(o) of the Act and therefore, IOP services are included in the wrap-around payment. We proposed to make revisions under § 405.2469 to reflect these changes.

The following is a summary of the public comments received on the FQHC supplemental payment for IOP services furnished in FQHCs and our responses:

Comment: Commenters were generally supportive of CMS' proposal on the FQHC supplemental payments. Some commenters stated that the proposed rule failed to acknowledge that health centers are reimbursed outside of the FQHC PPS rate for IOP, which requires a different supplemental payment rate methodology and strongly urged CMS to adopt a broader interpretation of the special payment rule to ensure health centers are paid up to the original Medicare amount that would be paid for IOP services, which is not FQHC PPS. Commenters requested that CMS clarify in the final rule that supplemental payments for Medicare Advantage (MA) beneficiaries cover the difference between the contract rate and the IOP service rate.

Response: We would like to reiterate that we stated in the CY 2024 OPPS proposed rule (88 FR 49717), that IOP services provided in an FQHC are also subject to the wrap-around payment. We stated that this provision ensures FQHCs are paid at least the Medicare amount for FQHC services, which includes FQHC PPS and now IOP services. Therefore, if the MA organization contract rate is lower than the amount Medicare would otherwise pay for FQHC IOP services, FQHCs that contract with MA organizations would receive a wraparound payment from Medicare to cover the difference (see § 422.316). We further stated that if the MA organization contract rate is higher than the amount Medicare would otherwise pay for FQHC IOP services, there is no additional payment from Medicare for IOP services.

After consideration of the public comments, we are finalizing our proposal as proposed, that is revising § 405.2469 to reflect that payment for IOP services are subject to the wrap-around payments.

5. Multiple Visits

a. Background

Currently, RHC and FQHC encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and a single location constitute a single visit, with the following exceptions:

- A patient has a medical visit and a mental health visit on the same day; or
- A patient has an initial preventive physical exam visit and a separate medical or mental health visit on the same day.

In the CY 2024 OPPS proposed rule (88 FR 49717), we explained that since IOP services are behavioral health services, we did not believe it would be appropriate to pay for a mental health visit and IOP services on the same day. In the case of a medical visit, an encounter can include a medical visit and a mental health visit or a medical visit and IOP services. An encounter cannot include two mental health visits on the same day. As such, we proposed to make amend § 405.2463(c) in the regulations to clarify that we will permit a mental health visit or IOP services on the same day as a medical visit.

The following is a summary of the public comments received on multiple visits for IOP services furnished in FQHCs and our responses:

Comment: We received a few comments on multiple visits. Commenters were generally supportive of CMS' proposal. Some commenters suggested that CMS allow, at a minimum, for an exception so that under emergency circumstances, an FQHC/RHC mental health visit could be furnished (and billable) on the same day that IOP services are provided. The commenters understood that that payment for IOP in FQHCs/RHCs, like IOP in other settings, will be subject to the clinician exclusions described in proposed 42 CFR 410.44(b) and that under this provision, the clinical services of various professionals, when delivered as part of an IOP care plan, are nonetheless unbundled and not paid for as IOP services under the OPPS, but instead, under the relevant Part B methodology. However, given that this provision will also apply to IOP furnished in FQHCs/RHCs, commenters stated that a prohibition on same-day payment for mental health visits in RHC/FQHC settings may be inappropriate. Other commenters strongly urged CMS to allow for a FQHC ''mental health visit'' to occur on the same day as IOP services. These commenters expressed concern that under the proposed rule, health centers risk providing a range of services to a patient without adequate reimbursement due to same-day billing restrictions and believe there could be instances where same-day IOP and mental health visits could occur. They stated as an example that when an IOP patient receives individual therapy sessions with physicians or psychologists as part of an IOP day, it appears that such a service would be billed separately under the relevant methodology (FQHC PPS). They further state that as patient centered medical homes, health centers should not be precluded from providing two different services to a patient on a single day and should be able to bill an FQHC PPS

mental health service and IOP service if delivered on the same day. Another commenter recommended CMS clarify that the IOP benefit does not preclude beneficiaries from receiving other services, including remote mental health services.

Response: We thank the commenters for raising these concerns. As we stated in the proposed rule (88 FR 49717), IOP services are behavioral health services, and we did not believe it would be appropriate to pay for a mental health visit and IOP services on the same day. We understand that in the HOPD setting, additional mental health services may be provided, but are capped at a payment amount not to exceed the IOP or PHP payment amounts. We did not intend to imply that additional services would not be reportable. Under the RHC AIR and FQHC PPS, when there are multiple visits on the same day, we permit those services to be reported, however, we only pay for one visit. We believe the same situation applies here, that is, if additional mental health visits are needed in addition of the 3–IOP services per day, we would expect an RHC or FQHC to report those services on the claim. Payment for the service would be included in the IOP rate similar to how the additional mental health services would be paid for under the OPPS.

After consideration of the public comments, we are finalizing our proposal with a clarification. We are amending § 405.2463(c) in the regulations to state that we will pay a mental health visit or IOP services on the same day as a medical visit. We are clarifying that if a mental health visit is furnished the same day as IOP services, all services are covered under Medicare Part B, however, we will only pay the IOP rate and the mental health visit will be considered packaged. While there could be emergency circumstances for which a mental health visit and IOP services are furnished, at this time we believe that it is unlikely that an FQHC or RHC would simultaneously have a specific patient enrolled in the IOP and need a separate and distinct mental health service delivered at the same FQHC or RHC, in a given day of service. In addition, we believe that the payment amount is adequate if these situations occur, since the rate is based on the costs associated with administering an IOP in the hospital setting which represent a resource intensive program and, therefore, we should not pay more for a day with individual services. As we mentioned above, we recognize that this is a new program for these settings, we encourage RHCs and FQHCs to report all of the services they furnish on the claim so that we can gather data. We plan to monitor utilization of IOP services in these and other settings to inform refinements in the future.

6. Other Regulatory Updates

In addition to the regulatory changes described in this section of the rule, we proposed a revision to § 405.2400 to reflect that 42 CFR part 405, subpart X, is based not only on the provisions of sections 1833, 1861(aa), 1834(o) of the Act, but also the provisions under section 1834(y) of the Act. We believed we inadvertently did not revise the regulations when the CAA, 2021 amended section 1834 of the Act to add new paragraph (y), as we discuss in the CY 2022 PFS final rule (86 FR 65205 through 65206).

We did not receive any comments on the proposal. Therefore, we are finalizing our proposal as proposed to revise § 405.2400 to reflect that 42 CFR part 405, subpart X, is not based only on the provisions of sections 1833, 1861(aa), 1834(o) of the Act, but also the provisions under section 1834(y) of the Act.

G. Modifications Related to Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

1. Background

Section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (Pub. L. 115–271, October 24, 2018) established a new Medicare Part B benefit category for OUD treatment services furnished by OTPs during an episode of care beginning on or after January 1, 2020. In the CY 2020 Physician Fee Schedule (PFS) final rule (84 FR 62630 through 62677 and 84 FR 62919 through 62926), we implemented Medicare coverage and provider enrollment requirements and established a methodology for determining the bundled payments for episodes of care for the treatment of OUD furnished by OTPs. We established new codes and bundled payments for weekly episodes of care that include methadone, oral buprenorphine, implantable buprenorphine, injectable buprenorphine or naltrexone, and non-drug episodes of care, as well as add-on codes for intake and periodic assessments, take-home dosages for methadone and oral buprenorphine, and additional counseling. For CY 2024, we proposed modifications to the regulations and policies governing Medicare coverage and payment for OUD treatment services furnished by OTPs in both the CY 2024 OPPS proposed rule (88 FR 49717 through 49723) as well as the CY 2024 PFS proposed rule (88 FR 52413 through 52416).

2. Statutory Authority for Coverage of Opioid Use Disorder Treatment Service Provided by OTPs

Intensive outpatient programs (IOPs) [American Society of Addiction Medicine (ASAM) Level 2.1 of Care] are diverse and flexible programs that can provide both a step-up and step-down level of care for the treatment of substance use disorders (SUDs). IOPs may offer a step-down level of care in cases where a patient has been stabilized in a hospital facility or residential treatment program but continues to need services to maintain or achieve further treatment progress. IOPs also offer a step-up level of care in cases where a patient may need a higher level of care that is more structured or intensive than what can be provided in a typical outpatient treatment setting that offers care on a less frequent basis.[168] IOPs can be housed in an OTP, specialty addiction treatment facility, community mental health center (CHMC), or another setting.[169] According to the National Substance Use and Mental Health Services Survey, as of 2021, approximately 557 OTPs offer IOP services nationwide (30.1 percent of SUD treatment facilities offering OTPs).[170] Section 4124 of the Consolidated Appropriations Act (CAA), 2023, which was enacted on December 29, 2022, provides for Medicare coverage and payment for IOP services in hospital outpatient department (HOPDs), CMHCs, rural health clinics (RHCs), and federally qualified health centers (FQHCs). However, section 4124 of the CAA, 2023 did not address coverage for IOP services furnished in OTP settings.

Section 1861(jjj)(1) of the Act defines ''opioid use disorder (OUD) treatment services'' as items and services that are furnished by an OTP for the treatment of OUD, including FDA-approved opioid agonist and antagonist

[168] *https://www.ncbi.nlm.nih.gov/books/NBK64088/.*

[169] The ASAM National Guideline for the Treatment of Opioid Use Disorder (2020): *https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2.*

[170] Substance Abuse and Mental Health Services Administration, National Substance Use and Mental Health Services Survey (N–SUMHSS), 2021: Annual Detailed Tables. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2023. Weblink: *https://www.samhsa.gov/data/sites/default/files/reports/rpt39450/2021%20N-SUMHSS%20Annual%20Detailed%20Tables_508_Compliant_2_8_2023.pdf.*