Optum

Quick Reference Guide

2024 Medicare Changes

Overview

A number of changes for Medicare and Medicare Advantage plans went into effect on Jan. 1, 2024. These changes were required by two key pieces of federal legislation and policy:

- The Consolidated Appropriations Act of 2023, H.R. 2617 version dated Dec. 29, 2022, expands the number of provider types who can provide services under Medicare Part B.
- The 2024 Medicare Advantage and Part D Final Rule from The Centers for Medicare & Medicaid Services (CMS). The final rule increases oversight of Medicare Advantage plans and seeks to better align Medicare Advantage coverage with traditional Medicare.

Please review the change briefs below and access the detailed summaries for more information.

Additional License Types Eligible for Medicare Part B

To help increase the availability of mental health providers to Medicare beneficiaries, 3 additional provider types have been added to the Medicare Part B covered provider list – Marriage and Family Therapists, Mental Health Counselors and Addiction Counselors.

Get the details

FQHCs and RHCs are now covered sites for Intensive Outpatient Services (IOP)

Beginning Jan. 1, 2024, IOP services may be delivered by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). As a distinct and organized program of psychiatric services, IOP services are distinct from mental health visits.

See the requirements

Payment rates updated for partial hospitalization services

The changes apply to partial hospitalization program (PHP) services furnished in hospital outpatient departments and Community Mental Health Centers (CMHCs). Per diem rates have increased and two new Ambulatory Payment Classifications (APCs) have been established for each provider type. Additionally, CMS has clarified coverage of PHP for the treatment of substance use disorders.

Review key points

Certified Opioid treatment programs can now provide IOP services

Medicare will pay for Intensive Outpatient Services (IOP) services provided by certified opioid treatment programs. Each service must be medically reasonable and necessary and cannot be duplicative of any service paid for under any bundled payments billed for an episode of care in a given week.

Learn more

Transition of care period for new Medicare Advantage plan enrollees

To avoid disruption in care, a 90-day treatment transition period for an active course of treatment has been established for members who transition from a previous health plan into a new Medicare Advantage plan.

Get the scoop

Updated appointment availability standards

The appointment wait time standards apply to both primary care and behavioral health services, including mental health and substance use disorder services.

Review the standards

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FQHCs and RHCs are now covered sites for Intensive Outpatient Services (IOP)

Beginning Jan. 1, 2024, IOP services may be delivered by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). These sites are in addition to the hospital outpatient departments and Community Mental Health Centers (CMHCs) settings that have previously been approved to provide IOP services.*

IOP is a distinct and organized outpatient program of psychiatric services provided for individuals who have an acute mental illness, including conditions such as depression, schizophrenia and substance use disorders. For FQHCs and RHCs, these services are distinct from mental health visits.

This section focuses on IOP services delivered in a FQHC or RHC. Below is a summary of key provisions that will affect facilities.

Plan of Care and Certification Requirements

- For all settings in which IOP services are delivered, a physician must determine that a patient needs a minimum of nine hours of IOP services per week.
  - Each patient must have an individualized, written plan of treatment outlining the physician's diagnosis; the type, amount, frequency, and duration of the items and services provided under the plan; and the goals for treatment. The plan is established by a physician, in consultation with appropriate staff participating in the IOP program.
- The treatment plan and need for IOP services must be reviewed at least every other month. At that time, the physician must document in the plan and associated treatment records that the patient continues to require IOP services for a minimum of 9 hours per week.

Claim Requirements

Coding and billing

- When billing for IOP services, FQHCs and RHCs are required to report condition code 92 to identify intensive outpatient claims and revenue code 0905.
- At least one IOP service from List A Primary Services must be included on the claim for payment.
  - Additional IOP services from List B Services listed on the claim will be bundled for that specific day.
- For additional information, review CMS Change Request 13264 which outlines billing requirements for FQHCs and RHCs,

Non-covered services

- Certain IOP services are not reimbursable when provided by FQHCs and RHCs.
  - For example, group therapy is considered an IOP service and payable via the IOP payment amount. However, if it is billed as a service provided by a FQHC or RHC, it is not reimbursable as an IOP services.

Reimbursement Details

IOP payment rate

- Two IOP Ambulatory Payment Classifications (APCs) have been established for each provider type – one for days with three services per day and one for days with four or more services per day.
- For grandfathered tribal FQHCs, payment is based on the lesser of a grandfathered tribal FQHC's actual charges or the Medicare outpatient per visit rate.

Multiple services provided on the same day

- When IOP services are furnished on the same day as a mental health visit, or on the same day as a medical visit, all medically necessary services are covered under Medicare Part B.
  - When IOP services are furnished on the same day as a mental health visit, CMS will make one payment at the IOP rate.
  - When IOP services are furnished on the same day as a medical visit, CMS will make two payments – one payment for the medical visit under the FQHC prospective payment system (PPS) and one payment for IOP services at the IOP rate.

***** *IOP services may be furnished in hospital outpatient departments (HOPDs), Community Mental Health Centers (CMHCs), Critical Access Department (CAH) outpatient departments. FQHC and RHCs. IOP services may also be furnished in Opioid Treatment Programs (OTPs) for the treatment of opioid use disorder (OUD*).

Payment rates and coverage updated for partial hospitalization services

A partial hospitalization program (PHP) is an intensive, structured outpatient program provided as an alternative to psychiatric hospitalization. To be considered as a PHP, patients must receive a minimum of 20 hours of services each week.

New APC per diem rates

Under the Outpatient Prospective Payment System (OPPS), Medicare payments for PHP services outline a specific group of mental health services paid on a per diem basis.

CMS has added two Ambulatory Payment Classifications (APCs) that increase payment rates for PHP services furnished in hospital outpatient departments and Community Mental Health Centers (CMHCs). This expansion of the rate structure applies to all provider types. The APCs are:

- Three services per day
- Four or more services per day

New payment calculation method

For calendar year 2024, CMS is calculating the payment rates based on cost per day using OPPS data that includes both PHP and non-PHP days. This is a change from the current methodology of using only PHP data. Incorporating the OPPS data set will allow CMS to capture data from hospital claims that are not identified as PHP but include the service codes and intensity required for a PHP day.

Substance Use Disorder treatment can be provided via PHP

CMS has confirmed that services provided for the treatment of Substance Use Disorder (SUD) and behavioral health are generally consistent with the statutory and regulatory definitions of PHP services. This means Medicare will reimburse PHP claims for the treatment of SUD, as long as PHP services are provided in lieu of inpatient hospitalization.

Certified Opioid treatment programs can now provide IOP services

To help increase access to behavioral health services, Medicare will now pay for Intensive Outpatient Services (IOP) provided by certified opioid treatment programs. Each service must be medically reasonable and necessary and cannot be duplicative of any service paid for under any bundled payments billed for an episode of care in a given week.

As permitted by state law and consistent with scope of practice requirements, the following practitioners may perform the required certification and plan of care requirements for IOP services furnished in the certified opioid treatment program setting:

- Physicians
- Nurse practitioners
- Physician assistants
- Clinical psychologists
- Clinical social workers
- Mental health counselors
- Marriage and family therapists
- Any other non-physician practitioners as defined in section 1842(b)(18)(C) of the Act

Claim submissions and reimbursement

Claims submitted for IOP services via a certified opioid treatment program must include G0137 as an add-on code. This new code is separate from the listing of PHP/IOP qualifying codes – it's a weekly bundle that meets the minimum IOP hours provided in a week. By using this code, certified opioid treatment programs will receive a weekly payment adjustment for the IOP services.

Transition of care for new Medicare Advantage plan enrollees

To avoid disruption in medically necessary care, a 90-day treatment transition period for a covered benefit has been established. The transition period applies to members who have an active course of treatment underway before they enroll in the Medicare Advantage plan.

The new Medicare Advantage plan must cover the active treatment through either through the end of the existing authorized treatment period or for a minimum of 90 days from the effective date of the new plan, whichever ends first. During the existing treatment period, the new Medicare Advantage plan may not require prior authorization for the active treatment to continue. Here's an example of how this requirement would apply:

- A member is undergoing an active course of treatment for a covered benefit that is 60 days in duration
- The member transfers to a new Medicare Advantage plan 30 days into the 60-day treatment period
- The new plan must cover the remaining 30 days of treatment without requiring additional prior authorization

More information will be available for Optum Behavioral Health providers in the next several months.

Updated appointment availability standards

CMS confirmed appointment wait time standards for members covered by a Medicare Advantage plan. These standard wait times apply to both primary care and behavioral health services, including mental health and substance use disorder services.

Type of Appointment	Minimum Standard Wait Time
Urgently needed services or emergency	Member is seen immediately
Services that are not emergency or urgently needed, but the enrollee requires medical attention	Member is seen within 7 business days
Routine and preventive care	Member is seen within 30 business days