BRIEF • MARCH 2025

Center for Health Care Strategies

Expanded Medicare Coverage of Intensive Outpatient Services: Considerations for States

By Gretchen Bell and Andrew Spicer, Center for Health Care Strategies, and Deborah Steinberg, Legal Action Center

KEY TAKEAWAYS

- As of January 2024, Medicare covers intensive outpatient program (IOP) services, closing a care gap for mental health and substance use treatment among Medicare enrollees.
- This new coverage, however, may also impact Medicaid, including potential implications for state budgets, managed care rates, provider incentives, beneficiary access, and care coordination for individuals dually eligible for both Medicare and Medicaid.
- Lack of awareness across stakeholder groups, billing confusion, and reimbursement differentials could affect service access and provider participation.
- This brief offers recommendations to guide states in enhancing member and provider awareness about IOP coverage changes, assessing payment rates, monitoring provider networks, and improving data sharing to advance person-centered care.

In November 2023, the Centers for Medicare & Medicaid Services (CMS) released the *Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System* final rule and the *Physician Fee Schedule* final rule. Both rules increase Medicare coverage of community-based mental health and substance use disorder (SUD) services, including implementing provisions of the Consolidated Appropriations Act of 2023. **As required by Congress, Medicare now covers intensive outpatient program (IOP) services as part of these rules, effective January 1, 2024**.

The launch of Medicare IOP coverage could have an array of implications for individuals covered by Medicaid, including people dually eligible for both programs. To understand these impacts, the Center for Health Care Strategies (CHCS) and the Legal Action Center (LAC) explored how this change might affect care coordination and access to IOP services for Medicaid-only and

Made possible with support from Arnold Ventures.

dually eligible populations. CHCS and LAC also examined state awareness of this coverage expansion, and any related state actions to address Medicaid budgets or managed care rates for these services.

The exploration included interviews with state Medicaid and behavioral health agency staff, behavioral health providers offering IOP services, and health plan representatives, as well as a virtual roundtable with advocacy groups focused on aging, disability, substance use, and mental health. This brief outlines key considerations for states and other Medicaid stakeholders to ensure continued and expanded access to IOP services. It highlights opportunities to build awareness among stakeholders about the new Medicare coverage, assess provider incentives, monitor access and network availability, and promote person-centered care coordination.

Understanding Medicare's New Coverage of IOP Services

Prior to January 2024, Medicare coverage for SUD and mental health care included inpatient care in psychiatric and general hospitals, prescription drugs, outpatient services, and partial hospitalization. Medicare enrollees who needed services more frequently than outpatient therapy, but less intensive than partial or inpatient hospitalization, fell into a coverage gap. Individuals in this gap had to pay out-of-pocket for IOP services or not receive them at all.

With CMS' 2024 final rule, Medicare now covers IOP services delivered in hospital outpatient settings, Medicare-certified community mental health centers, federally qualified health centers, or rural health clinics. Additionally, IOP services can now be provided through opioid treatment programs.

What are IOP services?

IOPs provide structured mental health and SUD treatment in an outpatient setting. IOPs serve as a critical treatment option along the continuum of care by providing more intensive treatment than weekly therapy or counseling, but less intensive care than inpatient, residential, or partial hospitalization psychiatric care. IOPs typically provide services for nine to 19 hours per week and allow people to live at home while receiving treatment. While services vary by provider and state, IOPs typically offer individual counseling, case management, group and family counseling, crisis services, medications and medication management, and peer services.

Services under the new Medicare IOP benefit include:

- Individual and group therapy with physicians, psychologists, or other behavioral health professionals;
- Occupational therapy services;
- Services of social workers, trained psychiatric nurses, and other professionals trained to work with patients with serious mental health needs, including people with SUD;
- Drugs provided for therapeutic purposes, excluding those self-administered;

- Activity therapies that are individualized and essential for treatment;
- Family counseling services, including counseling services for caregivers;
- Patient education programs, including caregiver training services; and
- Diagnostic services.

Notably, Medicare coverage only applies to in-person IOP services. Virtual IOPs and other telehealth options for IOPs are not covered by Medicare under the updated regulations. (Medicaid continues to cover telehealth options for IOP.)

Themes from Interviews and Stakeholder Convenings

CHCS and LAC conducted a series of interviews with state agencies, health plans, and behavioral health provider organizations to gather perspectives on the impacts to Medicaid of expanded Medicare coverage of IOP services. In addition to these targeted interviews, CHCS and LAC hosted a virtual roundtable that included advocates and individuals with lived experience. Through these activities, CHCS and LAC aimed to better understand awareness and education efforts, access to IOP providers, IOP service utilization, coordination of and access to care, and state Medicaid budget impacts. Specifically, we sought to understand how Medicaid stakeholders were planning for and assessing the potential impacts of this coverage change. Following are key themes from these interviews and roundtable discussions.

Stakeholders lack general awareness of the policy change.

A central theme from interviews with state agencies was an overall lack of awareness of and limited attention to Medicare's new coverage of IOP services. Given other pressing priorities, most interviewees had limited knowledge of the policy change and had not yet considered its potential impacts on providers, beneficiaries, or budgets. Nonetheless, state representatives expressed a desire to ensure access to IOP services, recognizing the benefits of providing more intensive mental health and SUD services outside of an inpatient or residential setting.

Similarly, some advocacy organizations had limited knowledge about how coverage of IOP services works and how people get admitted to this level of care. Participants were interested in how new Medicare coverage could expand access to mental health and SUD care for older adults and people with disabilities who are enrolled in Medicare. Roundtable participants saw a need to increase awareness about IOPs and how to access these programs through all types of insurance coverage.

IOP providers interviewed had greater awareness of the new Medicare coverage of IOP services and generally agreed that this coverage has the potential to increase access. Providers eligible to accept Medicare for these services were either already doing so or had plans to further expand their programs for Medicare beneficiaries. Interviewed providers who were not currently eligible to bill Medicare expressed an interest in doing so, noting that they currently had to deny services for Medicare patients on a routine basis. Some opioid treatment providers who had been previously unable to deliver IOP services to Medicare enrollees noted that the new coverage enabled them to expand their services for participants with all types of insurance.

Providers and health plans are unclear on billing and covered benefits.

Except for providers actively billing Medicare for IOP services, most interviewees were unclear on how to bill or code for IOP services under Medicare and how this would differ from Medicaid. Importantly, multiple providers expressed confusion about how they could bill for IOP services provided to individuals who are dually eligible for Medicare and Medicaid. Many providers, for example, believed they could not treat or be reimbursed for serving dually eligible individuals if they are not enrolled as Medicare providers.

Managed care and provider payment rates may require adjustments.

As Medicare becomes the primary payer of IOP services for dually eligible beneficiaries, there may need to be adjustments to Medicaid managed care rates. State interviewees expressed the need to analyze utilization and potentially adjust contracted rates with Medicaid managed care organizations (MCOs) in instances where they are no longer the primary payer for IOP services for dually eligible individuals.

The expansion of Medicare coverage may also impact provider payment rates, both among MCOs and among states where the IOP benefit is delivered on a fee-for-service basis. State interviewees expressed concerns that Medicare-Medicaid rate differentials may have access implications. For example, to the extent that Medicare rates are higher than Medicaid rates, as most interviewees indicated, providers may be incentivized to prioritize serving the Medicare population over people with Medicaid-only coverage.

States expressed concerns about network adequacy and its impact on access.

State interviewees had a good sense of the network of IOP providers for Medicaid enrollees in their states but were not tracking provider participation in Medicare. State interviewees were mixed on whether they had a sufficient provider network to support their Medicaid-only population. For example, one interviewee noted that their state did

not have enough IOP providers within their network, while another credited expanded Medicaid telehealth coverage with improving access to IOP services. Another state acknowledged a broad shortage of mental health and SUD providers but had not heard concerns about long waitlists or provider shortages specific to IOP. Similarly, another state representative had not heard concerns about long waitlists; however, they acknowledged that this could be because of the limited referral pathways for IOP services, such as when IOPs only accept individuals stepping down from a higher level of care within the provider's system. Many of the providers interviewed also indicated that they prioritize admitting patients already being treated within their program at higher levels of care.

State representatives noted that their agencies had not yet formulated plans to re-evaluate Medicaid network adequacy or access based on the new Medicare coverage. Interviewees were not aware of any disparities in access to IOP services, other than broader underutilization of behavioral health services. Several state interviewees were hopeful that the new Medicare coverage would incentivize additional providers to deliver IOP services. Lastly, states acknowledged that Medicare's expanded coverage could increase access to care for dually eligible individuals, but clear billing guidance would be key to lessening the burden on providers.

Care coordination may be impacted if Medicaid stakeholders receive reduced member data.

State representatives highlighted the potential impact of the new Medicare coverage on care coordination for dually eligible individuals. For example, interviewees were concerned that shifting to Medicare as the primary payer for IOP services could limit information sharing with states, MCOs and other Medicaid providers. This gap in information could limit service use and cause disruption in care coordination for dually eligible individuals.

During the roundtable discussion, people with lived experience and those from advocacy organizations noted that care coordination challenges could also extend to Medicaid-covered wrap around services, such as non-emergency medical transportation. Of note, when dually eligible individuals are enrolled in fully integrated care plans, where a single MCO administers and coordinates all Medicare and Medicaid benefits, the shift in the primary payer would not have the same potential impact on care coordination.

Stakeholders should ensure person-centered care.

Finally, a prominent theme among stakeholders, especially roundtable participants with lived experience or advocacy roles, was the importance of culturally competent providers and providers who understand the unique needs of older adults. IOPs are

designed to be tailored to the individual, ensuring that people receive care that meets their needs and circumstances. Roundtable participants noted that individuals with mental health conditions and SUD often face stigma and discrimination, including in health care settings. Roundtable participants also noted that IOP providers new to the Medicare population may lack the physical accessibility features, cultural training, or language skills to offer appropriate care to this population.

Recommendations for State Oversight of IOP Services Given New Medicare Coverage

Based on key takeaways from stakeholder interviews and roundtable discussions, following are recommendations for states and other Medicaid stakeholders to ensure expanded and coordinated access to IOP services.

1. Build awareness campaigns to inform stakeholders about the coverage change.

To minimize potential disruptions in access to IOP services for Medicaid enrollees due to the new Medicare coverage, state agencies, IOP providers, and other stakeholders need to understand the administrative and programmatic details of this coverage change. To address gaps in awareness, states can issue clear guidance to educate providers and plans on necessary adjustments to Medicaid authorization and billing, including clarifying any differences in coverage between Medicare and Medicaid (e.g., billing codes, allowable settings, telehealth). This may include developing fact sheets and FAQs on program structure and billing guidelines, creating training courses and standard operating procedures, and facilitating information sessions for a range of stakeholders, including referring providers, on the value of this level of care.

As part of this education, states might also consider how dually eligible individuals access IOP services (e.g., through various combinations of managed care and/or fee-for-service) and what clarifications or changes may be needed to better facilitate access to care and information-sharing between payers. States can clarify how providers not enrolled in Medicare can still bill Medicaid for IOP services provided to dually eligible individuals, as well as streamline this process to the extent possible.

2. Assess the need to modify provider reimbursement and MCO capitation rates.

Discrepancies in provider payment rates between Medicare and Medicaid may negatively impact Medicaid-only populations' access to IOP services. During interviews, state representatives noted that providers may be disincentivized to serve Medicaid-only individuals in locations where the Medicare reimbursement rate is substantially higher.

Accordingly, states may find it beneficial to monitor how the Medicare reimbursement rates affect access to IOP services for Medicaid-only and dually eligible members. In settings where Medicaid MCOs were previously responsible for IOP service payment for dually eligible individuals, capitation rates might need to be adjusted downward. Depending on current IOP service use, states could potentially see a positive budget impact.

3. Monitor and enforce network adequacy requirements.

To ensure thorough oversight of network adequacy and better understand if Medicaid-only and dually eligible individuals have sufficient access to services, states may choose to employ several approaches. These may include analyzing utilization data, conducting additional outreach, and partnering with consumer advocates, health plans, and community-based organizations to help states monitor access to IOP services. In addition to reimbursement rates, states may consider reviewing other factors that impact provider network participation, such as contracting standards, documentation requirements, and utilization management practices. States should ensure that these factors are implemented in a manner consistent with Mental Health Parity and Addiction Equity Act requirements to ensure that behavioral health benefits are comparable to medical benefits coverage.

Recent federal requirements for Medicare Advantage dual eligible special needs plans (D-SNPs) include new network adequacy standards for monitoring behavioral health providers that can deliver IOP and other outpatient services under the Outpatient Behavioral Health facility-specialty provider category. States can consider opportunities to incorporate these federal D-SNP network adequacy requirements, such as in their state Medicaid agency contracts (SMACs).

4. Promote data sharing to advance integrated, person-centered care coordination.

The new Medicare coverage of IOP services should prompt states to ensure effective care coordination for dually eligible individuals with behavioral health needs, especially for those receiving some behavioral health services through Medicare and others through Medicaid. Data sharing and communication are vital to ensuring that health plans and providers have a comprehensive picture of individuals' needs and service use. Data sharing is also imperative for individuals receiving wraparound services they require to address medical and health-related social needs.

D-SNPs play an integral role in care coordination for dually eligible individuals, and states can use their SMACs with D-SNPs to ensure accountability and minimize fragmentation. For example, states can require D-SNPs to share data about IOP service utilization with the state and other Medicaid entities to coordinate care for members. To support

information exchange, additional tools, such as memorandums of understanding, data use agreements, and patient consent forms, may be needed to allow community providers to share relevant behavioral health data. States may also consider conducting regular engagement with behavioral health providers and plans. These activities can support state efforts to ensure more integrated, person-centered care.

Looking Ahead

Introducing IOP services as a covered benefit under Medicare fills a longstanding gap in care for Medicare enrollees who did not have prior coverage through Medicaid or private insurance. Yet, it will be important for state Medicaid agencies to ensure there are no unintended consequences for their Medicaid populations, including but not limited to reductions in access to services or disruptions in care coordination. As efforts to advance Medicare and Medicaid integration continue across the U.S., incorporating behavioral health care and services into these efforts will help ensure that comprehensive care is provided to those covered by Medicare and Medicaid.

While this brief focuses on the new Medicare coverage of IOP services, its recommendations may broadly apply to other coverage overlaps between Medicare and Medicaid, particularly for dually eligible individuals.

ACKNOWLEDGMENTS

CHCS and LAC would like to thank representatives from the following organizations who participated in interviews and roundtable discussions that informed this brief: Center for Medicare Advocacy, Community Catalyst, Disability Policy Consortium, Disability Rights of California, Justice in Aging, National Association of State Mental Health Program Directors, National Council on Mental Wellbeing, National Health Law Center, Partnership to End Addiction, and Wildflower Alliance.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.