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September 3, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Medicare and Medicaid Programs; CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program (CMS-1807-P)

Dear Administrator Brooks-LaSure:

The National Board for Certified Counselors and Affiliates, Inc. (NBCC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Proposed Rule, CY 2025 Payment Policies under the Physician Fee Schedule.

NBCC is the certification organization that provides national certification and the nationally normed examinations for state licensure for counselors. Our affiliate the NBCC Foundation leverages the resources of NBCC and Affiliates for capacity building to expand mental health services in traditionally underserved and never-served communities. The Foundation administers the Minority Fellowship Program (MFP) for counselors, provides community capacity grants, and facilitates community-based mental health education and stigma-reduction programs. NBCC maintains standards and processes that ensure that counselors who become certified have achieved the highest standard of practice through education, examination, supervision, experience, and ethical guidelines. Established as a not-for-profit, independent certification organization in 1982, NBCC has decades of commitment to expanding access to and utilization of mental and behavioral health services in communities across the globe. NBCC provides the examinations used for professional counseling licensure by all 50 states, Puerto Rico, Guam, and the Virgin Islands. These examinations are the National Counselor Examination (NCE) and the National Clinical Mental Health Counseling Examination (NCMHCE).

On January 1, 2024, mental health counselors and marriage and family therapists were recognized as approved providers in the Medicare program—both in the traditional Medicare program and Medicare Advantage plans. NBCC believes the enrollment process so far has been a resounding success, with nearly 40,000 mental health counselors having successfully enrolled as Medicare providers as of June 30.

NBCC COMMENTS ON 2025 PROPOSED FEE SCHEDULE RULE

NBCC has reviewed the proposed 2025 Medicare Physician Fee Schedule Rule as it pertains to several provisions under "Advancing Access to Behavioral Health Services" and related behavioral health provisions. We commend CMS for proposing these important provisions that will improve access to behavioral health services for Medicare beneficiaries. Our comments on the following areas are provided below:

1. PHYSICIAN FEE SCHEDULE CONVERSION FACTOR
2. ADVANCING ACCESS TO BEHAVIORAL HEALTH SERVICES
   - Safety Planning Intervention (SPI) Services and Post-Discharge Follow-Up
   - Allowing Access to Behavioral Health Services Furnished via Digital Devices
   - Activating Coding and Payment for Interprofessional Consultation
   - CMS Requests for Comments
   - Payment for Services Furnished in Additional Settings, Including Freestanding SUD Treatment Facilities, Crisis Stabilization Units, Urgent Care Centers, and Certified Community Behavioral Health Clinics (CCBHCs)
3. EXTENSION OF TELEHEALTH PROVIDER PRIVACY
4. IMPROVING ACCESS TO SUBSTANCE USE DISORDER TREATMENTS
5. CAREGIVER SERVICES AND TELEHEALTH
6. RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS
7. RECOMMENDATIONS FOR CONSIDERATION BY CMS ON IMPLEMENTATION OF THE 2025 MEDICARE PHYSICIAN FEE SCHEDULE RULE

PHYSICIAN FEE SCHEDULE CONVERSION FACTOR

MPFS reimbursement relies on relative value units that are established for practice expenses and are adjusted for cost-of-living variations based on the location where a service is provided (otherwise known as Relative Value Units or "RVUs"). These values are multiplied by a conversion factor to equal a payment rate.

The CY2025 MPFS Conversion Factor (CF) is estimated to be 32.3562, which reflects a 0.05% budget neutrality adjustment—an increase from the 2024 Finalized MPFS Conversion Factor of 32.24. However, Congress passed legislation alleviating the CF reduction in March, resulting in a new CF of 33.2875 for services provided after March 8, 2024. As a result, the MPFS proposal is a 2.8% reduction of the 2024 Conversion Factor.

NBCC recognizes that CMS must comply with the statutory requirements of budget neutrality. However, we are deeply concerned that the current and proposed reimbursement rates for mental health counselors (MHCs) and other practitioners participating in Medicare program are insufficient to meet the needs of the health care system. MHCs are facing unsustainable levels of burnout, exacerbated by student loan debt, high caseloads, and inadequate reimbursement.

Medical inflation has also significantly surpassed updates to the CF for nearly 15 years.[1] As a result, NBCC strongly opposes the proposed 2.8% reduction in the Medicare Physician Fee Schedule Conversion Factor.

We urge CMS to explore all possible avenues to prevent payment decreases for counselors and other practitioners participating in the Medicare program.

ADVANCING ACCESS TO BEHAVIORAL HEALTH SERVICES

NBCC appreciates CMS's focus on behavioral health care in this year's Physician Fee Schedule Proposed Rule and urges CMS to finalize many of the excellent proposals contained within the rule. We do provide some suggested technical revisions.

Safety Planning Intervention (SPI) Services and Post-Discharge Follow-Up

CMS is proposing to implement separate coding and payment for Safety Planning Intervention (SPI) Services and/or telephonic post-discharge follow-up contacts after an emergency room visit or crisis encounter. These services are typically provided to patients with suicidality or displaying a risk of suicide. The proposed G-code is HCPCS code GSPI1:

> Safety planning interventions, including assisting the patient in the identification of the following personalized elements of a safety plan: recognizing warning signs of an impending suicidal crisis; employing internal coping strategies; utilizing social contacts and social settings as a means of distraction from suicidal thoughts; utilizing family members, significant others, caregivers, and/or friends to help resolve the crisis; contacting mental health professionals or agencies; and making the environment safe.
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> The add-on HCPCS G-code for SPI services would be billed along with an E/M visit or psychotherapy service. CMS is proposing that the procedure would take 20 minutes, resulting in a proposed RVU of 1.09, based on the valuation of CPT Code 90839 (psychotherapy for crisis).

For post-discharge telephonic follow-up contact interventions, CMS suggests that these calls are typically 10–20 minutes and are not within the scope of Medicare telehealth services since they do not substitute an in-person service. The Proposed Rule calls for creating a monthly billing code describing specific protocols for post-discharge follow-up contacts that occur after a patient is discharged from the emergency department following a crisis encounter. This bundled service would include four follow-up calls in a month, with each call lasting between 10 and 20 minutes. CMS is also proposing that the billing provider would need to have at least one successful phone interaction with the patient and unsuccessful attempts would not qualify for reimbursement. The proposed G-code is HCPCS code GFCI1:

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[1] Burton, R., Winter, A., Gerhardt, G., & Tabor, L. (2022, December 8). *Assessing payment adequacy and updating payments: Physician and other health professional services and supporting Medicare safety-net clinicians*. Medicare Payment Advisory Commission (MedPAC). https://www.medpac.gov/wp-content/uploads/2021/10/Tab-E-Physician-Updates-8-Dec-2022.pdf

> Post discharge telephonic follow-up contacts performed in conjunction with a discharge from the emergency department for behavioral health or other crisis encounter, per calendar month. We seek comment on whether we should consider finalizing a specified duration that HCPCS code GFCI1 could be billed following discharge, for example, allowing this code to be billed for up to two months following discharge or whether a longer duration would be appropriate, the number of calls per month, the billing structure (for example, four calls for each discharged patient), and any other relevant feedback. CMS is proposing to price this service based on a direct crosswalk to CPT code 99426 (Principal care management; first 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional), which is assigned a work value of 1.00 work RVUs.

Practitioners would be required to obtain verbal or written consent from their patient in advance of furnishing these services due to the Medicare beneficiary's cost-sharing obligation. Practitioners would acknowledge consent in the patient's medical record.

With suicide rates continuing to escalate among all ages across the nation, NBCC is appreciative of CMS recognizing the extent of this issue, especially among older adults, and for adding coding on safety planning interventions for patients at risk of suicide. This new code will enable MHCs and other mental health practitioners to provide evidence-based suicide safety planning. However, providers need a way to capture time spent performing safety planning interventions beyond the initial 20 minutes, so we suggest greater flexibility in reporting total time required to provide these critically important services.

Some studies have shown that for patients identified with elevated suicide risk, interventions that include SPI and up to seven post-discharge follow-up calls with the patient focused on identifying suicide risk factors, clarifying goals, safety, future planning, facilitating treatment engagement, and problem-solving, can reduce future suicidal behavior.2

In addition, the Proposed Rule regarding "safety planning interventions" uses a term that refers to just one of several brief interventions designed to reduce suicide risk. This rule should also include other approaches with stronger scientific support and demonstrated efficacy, especially "crisis response planning (CRP)," also known as "crisis coping cards." CRP is the only safety planning type approach that has been validated via randomized clinical trials.
Five randomized clinical trials of CRP have been published supporting the approach's efficacy:

> Bryan, C. J., Mintz, J., Clemans, T. A., Leeson, B., Burch, T. S., Williams, S. R., Maney, E., & Rudd, M. D. (2017). Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers: A randomized clinical trial. *Journal of Affective Disorders, 212,* 64–72. https://doi.org/10.1016/j.jad.2017.01.028

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[2] Miller, I. W., Camargo, C. A., Jr, Arias, S. A., Sullivan, A. F., Allen, M. H., Goldstein, A. B., Manton, A. P., Espinola, J. A., Jones, R., Hasegawa, K., Boudreaux E. D., & ED-SAFE Investigators. (2017). Suicide prevention in an emergency department population: The ED-SAFE Study. *JAMA Psychiatry,* 74(6), 563–570. https://doi.org/10.1001/jamapsychiatry.2017.0678

Bryan, C. J., Bryan, A. O., Khazem, L. R., Aase, D. M., Moreno, J. L., Ammendola, E., Bauder, C. R., Hiser, J., Daruwala, S. E., & Baker, J. C. (2024). Crisis response planning rapidly reduces suicidal ideation among U.S. military veterans receiving massed cognitive processing therapy for PTSD. *Journal of Anxiety Disorders, 102,* 102824. https://doi.org/10.1016/j.janxdis.2023.102824

Chen, W.-J., Ho, C.-K., Shyu, S.-S., Chen, C.-C., Lin, G.-G., Chou, L.-S., Fang, Y.-J., Yeh, P.-Y., Chung, T.-C., & Chou, F. H.-C. (2013). Employing crisis postcards with case management in Kaohsiung, Taiwan: 6-month outcomes of a randomized controlled trial for suicide attempters. *BMC Psychiatry,13,* 191. https://doi.org/10.1186/1471-244X-13-191

Lohani, M., Bryan, C. J., Elsey, J. S., Dutton, S., Findley, S. P., Langenecker, S. A., West, K., Baker, J. C. (2024). Collaboration matters: A randomized controlled trial of patient-clinician collaboration in suicide risk assessment and intervention. *Journal of Affective Disorders, 360,* 387–393. https://doi.org//10.1016/j.jad.2024.06.004

Wang, Y.-C., Hsieh, L.-Y., Wang, M.-Y., Chou, C.-H., Huang, M.-W., & Ko, H.-C. (2016). Coping card usage can further reduce suicide reattempt in suicide attempter case management within 3-month intervention. *Suicide and Life-Threatening Behavior, 46(1),*106–120. https://doi.org/10.1111/sltb.12177

We believe the wording of this Proposed Rule should be amended to ensure that the suicide prevention interventions with the strongest supporting evidence can be paid for as well beginning in 2025.

Allowing Access to Behavioral Health Services Furnished via Digital Devices

CMS is proposing Medicare payment to billing practitioners for digital mental health treatment (DMHT) devices furnished incident to or integral to professional behavioral health services used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care:

> CMS is proposing to create three new HCPCS codes for DMHT devices modeled on coding for RTM services. Practitioners who are authorized to furnish services for the diagnosis and treatment of mental illness would be able to bill a new HCPCS code: GMBT1 (Supply of digital mental health treatment device and initial education and onboarding, per course of treatment that augments a behavioral therapy plan) for furnishing a DMHT device.

CMS is also proposing to establish payment for HCPCS codes GMBT2:

> (First 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (DMHT) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the DMHT device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month) and GMBT3 (Each additional 20 minutes of monthly treatment management services directly related to the patient's therapeutic use of the digital mental health treatment (DMHT) device that augments a behavioral therapy plan, physician/other qualified health care professional time reviewing data generated from the DMHT device from patient observations and patient specific inputs in a calendar month and requiring at least one interactive communication with the patient/caregiver during the calendar month).

We applaud CMS for its proposal to enable access to digital mental health treatment. We appreciate that this proposal includes reimbursement not just for the supply of a digital product, but also for professional management of interventions furnished through the product. We recommend that CMS broaden the scope of devices to include medical and neurodevelopmental disorders to adequately cover the range of disorders treated by these FDA-cleared products.

Activating Coding and Payment for Interprofessional Consultation

NBCC fully supports CMS's proposal to establish a reimbursement mechanism for behavioral health clinicians engaging in interprofessional consultations for the treatment of their patients. MHCs are increasingly being called upon to consult on other providers' patients to integrate physical and mental health care services and extend the workforce. These consultations allow health care providers to collaborate and seek expert opinions without requiring the patient to be physically present. This proposal acknowledges the reality of modern behavioral health treatment, and we urge CMS to finalize this provision.

> Medicare currently allows for physicians to bill for interprofessional consultations between providers using CPT codes 99451, 99452, 99447, 99448 and 9499. MHCs, LCSWs, LMFTs and psychologists would be able to bill these codes or new HCPCS codes GIPC1–5. CMS is proposing to value the new G codes based on a crosswalk to existing CPT codes related to interprofessional consultations. The proposed work Relative Value Units (RVUs) for these G codes are as follows:
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> **GIPC1:** Work RVU of 0.35, cross walked to CPT code 99446.
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> **GIPC2:** Work RVU of 0.70, cross walked to CPT code 99447.
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> **GIPC3:** Work RVU of 1.05, cross walked to CPT code 99448.
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> **GIPC4:** Work RVU of 1.40, cross walked to CPT code 99449.
>
> **GIPC5:** Work RVU of 0.70, cross walked to CPT code 99451.
>
> **GIPC6:** Work RVU of 0.70, cross walked to CPT code 99452.

CMS does not propose any direct Practice Expense (PE) inputs for these G codes since the six CPT codes used for cross-walking do not have assigned direct PE inputs.

CMS REQUESTS FOR COMMENTS

Payment for Services Furnished in Additional Settings, Including Freestanding SUD Treatment Facilities, Crisis Stabilization Units, Urgent Care Centers, and Certified Community Behavioral Health Clinics (CCBHCs)

NBCC's comments in this section are in response to the request from CMS on page 151 of the Proposed Rule:

> Additionally, we are seeking comment on entities that offer community-based crisis stabilization, including 24/7 receiving and short-term stabilization centers, that provide immediate access to voluntary and/or involuntary care, without the need for a referral. Regarding such crisis stabilization units, we are interested in feedback on the following questions, as well as any other relevant feedback.

“What kind of services do crisis stabilization units provide? Do crisis stabilization units provide services similar to those described by the psychotherapy for crisis codes (CPT codes 90839 and 90840)?”

These services are not similar to those described in codes 90839/90840. Crisis stabilization is a longer-term service that can occur in the person’s home or in a crisis stabilization facility. The primary goal of crisis stabilization is to stabilize an individual’s condition, alleviate distressing symptoms, and facilitate a return to baseline functioning. This may involve medication management, brief psychotherapy, supportive crisis intervention strategies, and safety planning to address the individual’s immediate needs. Service includes follow-up after a crisis intervention.

These services are to be provided in the person’s own home, or another home-like setting, or a setting which provides safety for the person and the mental health professional. Stabilization services may include short-term assistance with life skills training and understanding medication effects. It may also include providing services to the person’s natural and community support, as determined by a mental health professional such as an MHC, for the benefit of supporting the person that experienced the crisis. Stabilization services may be provided prior to an intake evaluation for behavioral health services. Stabilization services may be provided by a team of professionals, as deemed appropriate and under the supervision of a mental health professional.

“Does the definition of crisis stabilization unit vary by State? If so, what are the variations and similarities across States?”

Crisis stabilization does vary by state, based on state law, state licensing requirements, and Medicaid state plans.

“If CMS outlined how crisis stabilization units could bill Medicare under the PFS, would there be an impact in underserved areas?”

Yes, there would be an impact, as the aging population can be seen in multiple crisis stabilization units across a given state. Units currently use state funding and block grant funding for services for individuals on Medicaid. This is the same funding that is available to support uninsured/underinsured individuals, including undocumented individuals. If services could be billed to Medicare, these limited funds would be freed up to support additional access to services for uninsured/underinsured individuals.

“To what extent do crisis stabilization units employ practitioner types who can supervise auxiliary personnel and bill Medicare for their services?”

Crisis Stabilization Units employ MHCs as well as other licensed mental health professionals.

EXTENSION OF TELEHEALTH PROVIDER PRIVACY

CMS lacks the statutory authority to extend the COVID-19 era telehealth waivers past their congressionally mandated expiration of December 31, 2024. However, CMS included proposals in the Proposed Rule to permanently allow for audio-only coverage for telehealth services and for physicians

and other practitioners to provide care via telehealth at their home address through December 31, 2025. The 6-month in-person behavioral health requirement would also be waived for behavioral health services provided by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) through December 31, 2025.

More patients than ever before have turned to digital health platforms, tools, and services to consult with mental health providers. Heightened utilization of Medicare telehealth services will be a critical factor in realizing greater value for Medicare and the populations it serves.

In 2020, several national counseling organizations worked together to create the Counseling Compact. As of June 27, 2024, this compact legislation has been passed and signed into law in 37 states, with several more states expected to introduce bill language in January 2025. The compact allows counselors to practice in multiple states while preserving the regulatory authority of their home state and any additional states where they are approved to practice.

A key objective of the compact is to enable the use of telehealth technology to enhance access to professional counseling services. We strongly believe that the Counseling Compact aligns with CMS's goal of improving access to mental health services. NBCC requests that CMS consider incorporating the language from the Counseling Compact into CMS statutes as you work to improve and expand access to care. Currently, 37 states have agreed to allow telehealth services through both the compact and state law.

Medicare provided guidance in 2021 on enrollment issues and compacts, but no guidance on the relationship of telehealth service reimbursement and compacts.[3]

As part of our request, we ask that CMS provide an updated "Clarification" to its 2021 guidance that focuses on telehealth reimbursement under compacts.

Mental Health Counselors

We support CMS's proposal to revise the regulation at § 410.78(a)(3) that an interactive telecommunications system may also include two-way, real time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site practitioner is technically capable of using an interactive telecommunications system—as defined as multimedia communications equipment that includes audio and video equipment permitting two-way, real-time interactive communication—but the patient is not capable of, or does not consent to, the use of video technology.

We support CMS's proposal to continue to permit the distant site practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their home through 2025. Since the outset of the COVID-19 Public Health Emergency (PHE), CMS has

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[3] Centers for Medicare & Medicaid Services. (2021). *Medicare clarifies recognition of interstate license compact pathways* (MLN Matters Number: SE20008 Revised). https://www.cms.gov/files/document/se20008.pdf

allowed providers furnishing services via telehealth from their homes to list a practice address rather than their home address. Allowing certain patients or clients to obtain the provider's personal address is unwise for the provider's safety or well-being. A further extension of this flexibility is necessary to ensure continued provider security in furnishing telehealth services.

We have continued concerns with requiring an in-person visit before an eligible individual can receive a telemental health service. The requirement places a special restriction on mental health services versus other telehealth services without any evidence to justify the stricter treatment of telemental health services. We reiterate that audio-only telemental health services should be available to any patient requiring mental health services (in other words, past level 4 or 5 evaluation, and management [E/M] visit codes or psychotherapy with crisis), and to both established and new patients. We also encourage CMS to keep paperwork burdens to a minimum to avoid wasted resources and provider burnout.

IMPROVING ACCESS TO SUBSTANCE USE DISORDER TREATMENTS

CMS is proposing several modifications to the policies governing Medicare coverage and payment for Opioid Use Disorder (OUD) treatment services furnished by Opioid Treatment Programs (OTPs), aiming to improve access, continuity of care, and health equity for Medicare beneficiaries.

MHCs play a crucial role in the comprehensive treatment plan for individuals with OUD by providing behavioral health services, counseling, and support.

OTPs should be able to continue to provide substance use counseling and individual and group therapy using audio-only technology when audio-video technology is not available to the beneficiary. This applies in situations where the beneficiary cannot use or has not consented to audio-video technology. The OTP intake add-on code can be used for billing the initiation of buprenorphine treatment via two-way audio-video communication. Audio-only communication can also be used for initiating buprenorphine treatment if audio-video technology is not available to the beneficiary if all other requirements are met.

CMS is proposing to allow OTPs to permanently furnish periodic assessments using audio-only communication technology when video is not available, starting January 1, 2025. This proposal aligns with the coverage for other telehealth services provided under the Fee Schedule for mental health disorders, including Substance Use Disorders (SUDs). CMS is proposing to allow OTPs to bill Medicare for treatment provided through video communications initiating SUD treatment using methadone.

We appreciate CMS's continued efforts to address the opioid epidemic and provide the following specific responses to related proposals in the CY2025 rule. We support CMS's efforts to expand the availability of OPTs to patients suffering from substance use disorder (SUD). With rates of drug overdose deaths reaching new heights, CMS's actions could not have come at a better time. We support the extension of audio-only telehealth as a modality of treatment for patients who live in rural and underserved areas lacking the infrastructure to support video telehealth interaction. We support CMS's proposal to allow the OTP intake add-on code (HCPCS code G2076) to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with methadone,

to the extent that the use of audio-video telecommunications technology to initiate treatment with methadone is authorized by the Drug Enforcement Agency (DEA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) at the time the service is furnished.

We also applaud CMS for establishing a payment mechanism for Social Determinants of Health Risk Assessments within OTPs that seek to identify the social factors that influence the prevalence and severity of a patient's substance use. We support CMS's proposal to update the payment rate for intake activities described by HCPCS code G2076 by adding in the value of the non-facility rate for SDOH risk assessments described by HCPCS code (G0136).

CAREGIVER SERVICES AND TELEHEALTH

We ask CMS to finalize adding caregiver training services to the permanent CMS Telehealth list. We support CMS's effort to expand caregiver services through the addition of codes GCTB1 and GCTB2 but believe the value for these services should be cross-walked to a more analogous service, such as CPT code 90832, which describes individual psychotherapy, instead of code 97550, which describes training for a patient's physical and functional performance. In 2021 alone, about 38 million Americans spent a total of 36 billion hours caring for adults with serious health conditions, often with little notice and limited support when they start their caregiving role. There is ample evidentiary support for this type of training, which is the gold standard approach for treating patients with multiple health behavior challenges.

RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

CMS is seeking to allow Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) greater flexibility in the services they can offer, including behavioral health services, by making changes to their Conditions for Certifications and Conditions for Coverage (CfCs).

RHC providers and rural health associations have identified a discrepancy in guidance, statute, and regulations governing the RHC program. The CMS State Operations Manual states that "RHCs may not be primarily engaged in specialized services." The guidance specifies that being "primarily engaged" means that more than 50% of an RHC's operating hours must involve the provision of RHC services. This contrasts with statute, which refers to being primarily engaged in "furnishing to outpatients" services by physicians, physician assistants, nurse practitioners, clinical psychologists, or clinical social workers. The CfCs at § 491.9(a)(2) codify this by requiring RHCs and FQHCs to be primarily engaged in "providing outpatient health services." CMS has enforced a standard that RHCs must be primarily engaged in providing primary care services based on the CMS State Operations Manual.

To provide clarity, CMS is proposing to explicitly require RHCs and FQHCs to provide primary care services and that RHCs cannot be a rehabilitation facility primarily providing treatment of "mental diseases." Under this proposal, RHCs would still be required to provide primary care services to their patients. However, CMS would no longer enforce the standard that RHCs must be "primarily engaged in furnishing primary care services" and no longer assess whether a majority (more than 50%) of an RHC's operating hours are dedicated to primary care services during the survey process.

NBCC supports CMS's proposal to allow RHCs more flexibility in providing a range of services, including specialty and behavioral health care, by not limiting primary care services to most of their operating hours. In addition, we ask that the definition in the statute—which refers to being primarily engaged in "furnishing to outpatients"—include MHCs and MFTs. These changes will allow RHCs to offer greater flexibility in offering behavioral health services to underserved populations in rural areas.

CMS emphasizes that the clarification of RHCs not being a rehabilitation facility providing treatment of "mental diseases" is not meant to discourage behavioral health services to its patients in addition to the primary care it already provides. CMS acknowledges that the term "mental diseases" is outdated and not often used in the field of mental health today. The term is used in the statute and cannot be changed without congressional action. For the purposes of this proposed rule, the term "mental diseases" refers to mental and substance use disorders.

To prevent unintended consequences and protect access to these essential services, NBCC endorses NARHC's recommendation to define specific facility types, such as Certified Community Behavioral Health Clinics (CCBHCs) and Community Mental Health Centers (CMHCs), rather than redefining the term "mental diseases." Defining this term could lead to unintended barriers of access to behavioral health services at RHCs.

NBCC also wants to highlight that as frontline providers serving America's most vulnerable populations, FQHCs and RHCs should be able to utilize digital health technologies in all ways possible that will help them improve outcomes for their communities in more efficient ways. We support the steps CMS has already taken to extend the ability of FQHCs and RHCs to offer mental health services via telehealth and urges CMS to avoid unnecessary in-person requirements for FQHCs and RHCs when they use telemental health services.

RECOMMENDATIONS FOR CONSIDERATION BY CMS ON IMPLEMENTATION OF THE 2025 MEDICARE PHYSICIAN FEE SCHEDULE RULE

Clinical Supervised Experience and Documentation of Supervised Hours

Again, we would like to thank CMS for proposing the option of allowing applicants to have performed at least 3,000 hours of post-master's degree clinical supervised experience in place of at least 2 years of experience to qualify as a Medicare provider.

Many older MHCs and MFTs have difficulty in locating documentation of their clinical supervised experience hours when they were initially licensed. It is likely that MHCs and MFTs other than very recent graduates have not retained copies of weekly logs and experience verification forms in connection to licensure, and therefore providing documentation in connection to Medicare enrollment could be problematic. In addition, it is possible that the supervisors might be deceased, disabled, or otherwise unable to verify that the supervision occurred or the details of the supervision. We request that for any MHC and MFT graduate who has not graduated within the last 5 years, or who attests that their supervision was performed by someone who due to death or disability is unable to verify supervision, be presumed to meet the supervision requirements if they are licensed in their state with similar requirements.

Payment: Condition for Medicare Payment

This provision requires that "A claim for physician services, clinical psychologist services, or clinical social worker services must include appropriate diagnostic coding for those services using ICD–9–CM." We ask that MHCs and MFTs are included in this provision.

Merit–Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive

Both Licensed Clinical Social Workers (LCSWs/SWs) and psychologists are included as MIPS and APM eligible clinicians. We request that MHCs and MFTs are included in these initiatives.

Payment: Exceptions to the Referral Prohibition Related to Compensation Arrangements

MHCs and MFTs are left out of the nonphysician practitioner definition: "nonphysician practitioner' which means a physician assistant as defined in section 1861(aa) (5) of the Act, a clinical SW as defined in section 1861(hh) of the Act, or a clinical psychologist as defined as 410.71(d) of this subchapter." We ask that MHCs and MFTs are included in this definition.

Hospital Services Excluded From Payment Under the Hospital Outpatient Prospective Payment System

The rule lists the services not paid for under the hospital outpatient prospective payment system (except when packaged as a part of a bundled payment) as those of all known Medicare providers, including SWs and psychologists, with the exception of MHC and MFT services. We ask that the 2025 final rule address this omission to include MHCs and MFTs.

Partial Hospitalization Services

The provision references "social workers" in general and allows individual and group therapy by "other mental health professionals." However, psychologists are billed separately. We ask to add MHCs and MFTs to the list of authorized partial hospitalization providers.

Programs of All–Inclusive Care for the Elderly (PACE)

Medical social workers are referenced in 460.40 for sanctions. For other references, master's social workers are listed as part of an interdisciplinary team, but not psychologists. PACE mostly provides services to dual eligibles but also to those only covered by Medicare. We ask for more clarity on this provision for MHCs and MFTs.

Hospice Interdisciplinary Groups (IDG)

MHCs and MFTs are included in 418.56 as part of the interdisciplinary team. However, they are not listed as Medical social service providers as social workers are in 418.64 (referenced in 418.202). MHCs and MFTs are added as non-licensed personnel under 418.114(c), but MFTs and MHCs do not fit with this definition.

Under the CAA, the language on inclusion of MFTs and MHCs in IDGs states that IDGs should “at least” include a Social Worker, MHC, or MFT. We seek clarification on this provision in the final rule that states the IDG can include both a SW and MHC or a SW and MFT—not just one provider. We interpreted the provision that two of three providers could participate in the IDG.

In the proposed rule, CMS describes the unique roles these providers can play in addressing the needs of the patient, and that the patient and family should have an opportunity to tap into all the incredibly important expertise available during the hospice process. We seek clarifying language on this provision in the 2025 final rule to establish that more than one provider can participate in the IDG.

Home Health Services

We ask for MHCs and MFTs to be included in this provision. It defines “standard social worker” to include those with a master’s degree in social work. Assistant social workers are defined. Psychologists are not defined. The skilled professional services for mental health care appear to be Medical social work services.

Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities (CORFs)

Social workers and psychologists are both defined but can include those with just a bachelor’s degree as long as they are licensed, if applicable. We ask for MHCs and MFTs to be included in this provision.

Coverage for End State Renal Disease (ESRD)

We recommend that MHCs be eligible to be referenced as part of an interdisciplinary team for ESRD. We note that only social workers are defined as part of the interdisciplinary team. Counseling services are allowed as chosen by a social worker. Social workers must have at least a master’s degree, which is the same level of education as MHCs.

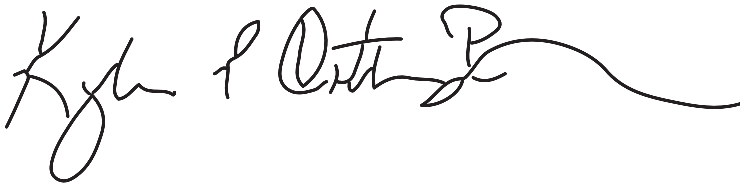
Addressing Social Determinants

NBCC supports CMS’s proposals to establish separate coding and payment for community health integration (CHI) services, principal illness navigation (PIN) services, and the social determinants of health (SDOH) risk assessment. We commend CMS for recognizing the valuable role of the various members of the interdisciplinary teams that treat people with mental health conditions, including community health workers, patient navigators, and peer support specialists. Integration of these trusted members of the community into health care settings has been shown to reduce health care spending and improve health outcomes. **We recommend that MHCs and MFTs be added to the interdisciplinary teams.** These proposals will help address many of the harmful economic and social conditions that affect the health of Medicare beneficiaries, which is reasonable and necessary for the diagnosis and treatment of mental health and medical conditions given the significant impact of SDOH.

CONCLUSION

Thank you for your attention to these comments. We thank CMS for their important initiatives to expand access to behavioral health services for older adults through the Medicare Physician Fee Schedule. These efforts will go a long way to improve the mental health of Medicare beneficiaries.

If you have further questions, please contact Kylie Dotson-Blake, PhD, NBCC President and CEO, at dotson-blake@nbcc.org.



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