nbcc
NATIONAL BOARD FOR CERTIFIED COUNSELORS® AND AFFILIATES

3 Terrace Way
Greensboro, North Carolina
27403-3660 USA

TEL: 336-547-0607
FAX: 336-547-0017
WEB: nbcc.org

January 24, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–4208–P, Mail Stop C4–26–05,
7500 Security Boulevard
Baltimore, MD 21244–1850

Re: Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P)

The National Board for Certified Counselors and Affiliates appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) ***Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-P)***.

The National Board for Certified Counselors, Inc. and Affiliates (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 and 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 board 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 include the National Counselor Examination (NCE) and the National Clinical Mental Health Counseling Examination (NCMHCE).

NBCC has reviewed the Proposed Rule and we commend CMS for proposing important provisions that would improve access to behavioral health services for Medicare beneficiaries. We have the following comments, which include implications for mental health counselors (MHCs):

Strengthening Prior Authorization and Utilization Management Guardrails

Medicare Advantage (MA) plans are facing increased scrutiny over their coverage and authorization practices, prompting significant reform initiatives from CMS. A particularly concerning statistic reveals that MA plans reverse 80% of their claim denials upon appeal, yet only a small fraction of denied claims are actually appealed. This suggests widespread inappropriate claim denials that go unchallenged. In response, CMS is implementing new rules based on their 2024–2025 utilization management audits. These reforms aim to streamline the prior authorization process, increase transparency in coverage decisions, and reduce unnecessary barriers to care. The new guidelines will better define when MA plans can implement utilization management, require more transparent coverage policies, strengthen appeals rights communication, and address payment issues related to reversed decisions. Additionally, CMS is developing systems to track detailed information about coverage decisions and appeals, allowing for better oversight of MA plans' authorization practices and their impact on health care access, particularly in rural areas.

The 2024 Medicare Advantage and Part D final rule introduces important changes to how MA organizations handle coverage decisions. The new regulations establish clear guidelines for basic benefits coverage and create specific parameters for when MA plans can implement their own coverage criteria. A key aspect of these changes requires MA organizations to align their coverage policies with Traditional Medicare standards, including following established Medicare laws, national coverage determinations (NCDs), and local coverage determinations (LCDs). Only when Traditional Medicare lacks specific criteria can MA plans develop their own internal standards. The rule also mandates transparency by requiring MA organizations to make their coverage criteria publicly available and establishes new consumer protections regarding prior authorization processes. Additionally, each MA organization must now maintain a dedicated utilization management committee to oversee and approve coverage policies. These comprehensive reforms, which took effect on January 1, 2024, aim to create a more standardized and transparent coverage system across Medicare programs.

CMS is introducing four significant changes to strengthen MA regulations regarding coverage and benefits administration. These modifications clarify several crucial aspects of MA operations. The first change addresses appeal rights, establishing that enrollees cannot be denied appeal rights until an MA organization has made a formal payment determination, even when there appears to be no payment liability. The second modification expands the definition of organizational determinations to include real-time coverage decisions made during service delivery, such as decisions about inpatient versus outpatient status, making these decisions subject to appeal processes. Third, the proposals enhance communication requirements, ensuring providers receive proper notification when they request determinations on behalf of enrollees. The final change limits MA organizations' authority by removing their discretion to reopen previously approved inpatient hospital admissions, providing greater stability and certainty in health care delivery decisions.

NBCC supports the substantial modifications related to prior authorization programs.

The implications of these MA regulatory changes specifically for MHCs include:

<u>Coverage and Payment Determinations</u>

- MHCs will have clearer processes for service authorizations
- Reduced risk of retroactive payment denials
- Better protection when providing ongoing treatment
- More predictable revenue streams for counseling practices

<u>Appeal Rights and Patient Care</u>

- Stronger position to advocate for appropriate levels of care for clients
- Better ability to challenge inappropriate coverage denials
- Protection against premature termination of treatment
- More leverage in determining appropriate treatment duration

<u>Administrative Processes</u>

- More transparent notification requirements help MHCs stay informed about coverage decisions
- Clearer communication channels with MA plans
- Reduced uncertainty about authorization status
- Better documentation trail for appeals and determinations

<u>Practice Management Implications</u>

- Need to update office procedures to align with new requirements
- Opportunity to improve authorization tracking systems
- More predictable practice management
- Potentially reduced administrative burden

Service Delivery Impact

- Greater stability in treatment planning
- Better ability to maintain continuity of care
- More protection for longer-term therapeutic relationships
- Clearer parameters for service intensity decisions

Client Access

- Improved ability to advocate for appropriate levels of care
- Better protection against arbitrary service limitations
- More stable therapeutic relationship

Ensuring Equitable Access to Medicare Advantage (MA) Services—Guardrails for Artificial Intelligence (§ 422.112)

The Rule highlights that under President Biden's Executive Order from October 30, 2023, federal agencies must ensure artificial intelligence (AI) implementation upholds equity and civil rights, with special emphasis on health care applications.

This Executive Order is particularly significant because:

- It's the first comprehensive federal directive on AI in health care
- It addresses growing concerns about AI bias in medical decision-making
- It creates accountability for both AI developers and health care providers

The CMS requirements specifically target several known issues with health care AI:

- Historical bias in medical datasets
- Potential discrimination in resource allocation
- Transparency in automated decision-making
- Equal access across different demographic groups

MA plans serve over 30 million beneficiaries (about half of all Medicare enrollees), making these AI guidelines particularly impactful for health care delivery to seniors and disabled Americans.

NBCC supports the proposed AI guardrails by CMS that aim to prevent inequitable treatment and access to care by MA plans by requiring them to disclose their use of AI tools; ensure equitable access through AI usage; and adhere to existing Medicare regulations, essentially guaranteeing that AI is used fairly and doesn't discriminate against beneficiaries based on their health status or other factors.

Key points about these guardrails:

- Transparency: MA plans must disclose how they are using AI tools within their operations, including the specific functions and purposes of the AI systems used.

- Equitable Access: AI systems used by plans must not hinder or restrict access to MA services and must be designed to promote equitable treatment for all enrollees.

- Adherence to Regulations: The use of AI must comply with existing Medicare regulations, ensuring that it does not violate any rules regarding discrimination, access to care, or other relevant guidelines.

- Potential for Bias Mitigation: CMS aims to address concerns about bias in AI algorithms by requiring plans to implement measures to identify and mitigate potential biases that could lead to unequal treatment.

AI Definitions

CMS is proposing three (3) key definitions that **NBCC supports**:

Automated System Definition

For this policy, CMS is proposing defining an "automated system" in § 422.2, drawing from the Blueprint for an AI Bill of Rights. The proposed definition states that an automated system is any computational system, software, or process that:

- Determines outcomes
- Makes or assists in decision-making
- Guides policy implementation
- Gathers data or observations
- Interacts with individuals, communities, or both

This definition is particularly important because it:

1. Establishes the scope of systems that will be subject to regulation
2. Aligns with federal guidance on AI governance
3. Covers both fully automated and human-assisted systems
4. Encompasses a broad range of healthcare applications

CMS highlights that automated systems include, but are not limited to, systems derived from machine learning, statistics, or other data processing or AI techniques, and exclude passive computing infrastructure. 'Passive computing infrastructure' is any intermediary technology that does not influence or determine the outcome of decision, make or aid in decisions, inform policy implementation, or collect data or observations, including web hosting, domain registration, networking, caching, data storage, or cybersecurity.

This distinction between active automated systems and passive infrastructure is crucial because it:

1. Clarifies which technologies fall under regulatory oversight
2. Helps organizations determine which of their systems need to comply
3. Prevents unnecessary regulation of basic IT infrastructure
4. Focuses oversight on systems that actually impact decision-making

This definition applies specifically to automated systems capable of significantly affecting individuals' or communities':

- Rights
- Opportunities
- Access to services or resources

This scope limitation is important because it:

1. Creates a materiality threshold for regulation
2. Focuses oversight on high-impact systems
3. Helps organizations prioritize which systems need closer monitoring
4. Excludes minor automated processes that don't meaningfully affect people's lives

Patient Care Decision Support Definition

In alignment with 45 CFR 92.4, CMS is proposing defining a "Patient care decision support tool" as any tool, mechanism, method, or technology—whether automated or not—that MA organizations use to facilitate clinical decision-making in their healthcare programs and activities.

Given the rapidly evolving health care technology landscape, these tools can take many forms, including:

- Basic flowcharts and clinical guidelines
- Complex computer algorithms
- Decision support interventions
- Predictive models

These tools support various health care functions:

- Screening and risk assessment
- Diagnosis and prognosis
- Clinical decision-making
- Treatment planning
- Health care operations
- Resource allocation

Importantly, CMS acknowledges that these decision support tools can potentially perpetuate discrimination and may adversely affect health outcomes for historically marginalized populations.

This definition is particularly significant because:

1. It encompasses both traditional and AI-powered tools
2. It acknowledges both benefits and risks of decision support systems
3. It explicitly addresses equity concerns
4. It provides flexibility to accommodate future technological developments

Artificial Intelligence Definition

As defined in 15 U.S.C. 9401(3), "artificial intelligence" or "AI" refers to a machine-based system that generates predictions, recommendations, or decisions to achieve specified human-defined objectives within real or virtual environments. These systems operate by:

- Perceiving real and virtual environments through machine and human-based inputs
- Automatically analyzing these perceptions to create abstract models
- Using these models to generate information or action options through inference

This definition is particularly important because it:

1. Establishes the legal framework for AI regulation in health care
2. Distinguishes AI from other types of automated systems
3. Emphasizes the role of human-defined objectives
4. Highlights the sequential process of how AI systems operate

NBCC supports regulations that:

Address Privacy and Data Security

- Create strict data protection laws that secure sensitive client information used by AI systems.
- Promote the use of technologies such as encryption and anonymization to safeguard client data.

Address Bias and Fairness

- Work with AI developers through government oversight to incorporate fairness audits into the development and deployment of AI systems in mental health to identify and mitigate bias.
- Encourage regulations that mandate the use of diverse datasets and the testing of AI systems across varied populations to prevent discriminatory outcomes.

Ensure Human Oversight for Inclusion

- Support the development of regulations that require a human element in the review and diagnostic process, ensuring that AI is used as a supportive tool rather than a replacement for human judgment.
- Create a resource to provide training for mental health professionals in the use of AI tools to enhance, not replace, their expertise in diagnosis and treatment.

Reference: "National Board for Certified Counselors (NBCC) – Policy, Advocacy, and Research in Counseling Center (PARC)"

The application of AI technology in behavioral health care can provide great benefits to overall mental health. AI can improve the accessibility of mental health services by providing online platforms or applications that anyone, anywhere, can access without waiting for an appointment schedule. This is very helpful for individuals who live in remote areas or have limited mobility.

AI systems excel at scaling their operations, capable of managing numerous cases concurrently while maintaining consistent service quality. This scalability dramatically reduces wait times and expands health care accessibility. Through sophisticated behavioral analysis and monitoring capabilities, AI can identify specific developmental patterns and therapeutic requirements for each patient. Furthermore, AI's adaptability allows for personalized treatment approaches, dynamically adjusting intervention strategies, communication styles, and session durations to match individual patient needs.

As a powerful analytical tool, AI can serve as an invaluable resource for mental health professionals in developing comprehensive care plans. By processing and analyzing vast amounts of client data, including session transcripts, behavioral patterns, and treatment responses, AI can provide MHCs with detailed insights that might otherwise take months to surface. These AI-generated analyses can highlight subtle patterns in client behavior, identify potential risk factors, and suggest evidence-based intervention strategies that align with the client's specific needs.

When preparing for client sessions, MHCs can review these AI-generated insights to make more informed decisions about treatment approaches, ultimately leading to more effective and personalized care plans. However, it's crucial to note that AI serves as a complementary tool rather than a replacement for professional judgment, enhancing rather than superseding the counselor's and therapist's expertise and clinical experience.

AI technology can play a crucial role in bridging mental health care gaps while supporting diverse representation in the field. Through AI-powered training simulations, aspiring MHCs from underserved communities can access high-quality educational resources and practical experience, even in areas with limited training facilities. AI can provide culturally sensitive training modules, translate materials into multiple languages, and offer personalized learning paths that accommodate different cultural perspectives and approaches to mental health care.

Furthermore, AI tools can help identify underserved areas and populations, enabling more strategic deployment of mental health resources and professionals. By reducing operational costs and administrative burdens, AI also makes it more feasible for MHCs from diverse backgrounds to establish and maintain practices in their communities, thereby creating a more inclusive and accessible mental health care system.

This regulation establishing guardrails for AI usage has significant implications for MHCs who work with Medicare populations. The key impacts include:

<u>Clinical Decision-Making Requirements</u>:

- Counselors must ensure that AI tools used in patient care meet Medicare's standards for algorithmic fairness and transparency
- AI recommendations cannot be the sole basis for treatment decisions; counselors must maintain primary clinical judgment
- Documentation must clearly distinguish between AI-assisted and human clinical decisions

Patient Protection Measures:

- Counselors must inform patients when AI tools are being used in their care
- AI systems must be regularly validated to prevent discriminatory outcomes across different demographic groups
- Patient data used in AI analysis must meet enhanced privacy and security requirements

Practice Implementation:

- Mental health practices must audit their AI tools to ensure compliance with Medicare standards
- Additional documentation requirements when using AI for treatment planning or progress monitoring
- Regular staff training on appropriate AI usage within Medicare guidelines

Reimbursement Considerations:

- Services utilizing AI must meet specific documentation requirements for Medicare reimbursement
- Practices must demonstrate appropriate human oversight of AI-assisted services
- Clear distinction between billable counselor time and AI-automated services

These guardrails aim to protect patient interests while allowing MHCs to responsibly leverage AI technologies to enhance care delivery and practice efficiency.

Format Provider Directories for Medicare Plan Finder (MPF)

The Medicare Plan Finder (MPF) serves as a crucial online tool that helps Medicare beneficiaries compare and select MA and Part D plans based on factors like benefits, premiums, deductibles, and Star Ratings. Currently, however, users face a cumbersome process when searching for in-network providers, as they must separately consult each plan's website or PDF directories. To streamline this experience, CMS is proposing a significant enhancement to MPF that would integrate provider network information directly into the platform. This update would require MA organizations to submit their provider directory data to CMS for inclusion in MPF, maintain its accuracy through regular attestations, and update any changes within 30 days. To maintain data quality, plans must adhere to specific compliance standards and quality checks, with detailed technical requirements forthcoming. This integration aims to create a more user-friendly, comprehensive tool that allows beneficiaries to make better-informed health care decisions in one convenient location.

The implications of these Medicare Plan Finder (MPF) changes specifically for MHCs include:

Practice Visibility

- MHCs will have increased visibility to Medicare beneficiaries searching for providers
- Potential to reach more Medicare patients through direct listing in MPF
- Greater opportunity to compete with other mental health providers
- Easier for potential clients to find MHCs accepting their specific MA plan

Network Participation Benefits

- Being listed in MPF could become a significant practice-building advantage
- More direct connection between MA network participation and client acquisition
- Potential increase in referrals from being more easily discoverable
- Better positioning in competitive markets

Administrative Responsibilities

- Need to ensure practice information is accurately maintained with MA plans
- Important to monitor how practice is listed in MPF
- Must stay vigilant about updating contact and availability information
- Critical to verify network status is correctly reflected

Practice Marketing Implications

- Less need for independent marketing to Medicare beneficiaries
- MPF listing becomes a new marketing channel
- Opportunity to stand out through accurate, complete profile information
- May influence decisions about which MA networks to join

Client Access Improvements

- Easier for clients to verify counselor participation in their plan
- Reduced confusion about network status and coverage
- More informed clients at first contact
- Potentially shorter time from search to first appointment

Strategic Planning Considerations

- May influence decisions about which MA plans to contract with
- Could affect practice growth strategies
- Importance of maintaining up-to-date online presence
- Need to align practice capacity with potential increased visibility

Ensuring Equitable Access to Behavioral Health Benefits Through Section 1876 Cost Plan and MA Cost Sharing Limits (§§ 417.454 and 422.100)

To enhance behavioral health care accessibility, CMS is aligning MA and Section 1876 Cost Plans' in-network cost sharing with Traditional Medicare rates. This alignment aims to balance affordability with maintaining stable access to care. The proposed cost-sharing structure includes three key changes:

- Mental health specialty care, psychiatric services, partial hospitalization/intensive outpatient care, and outpatient substance abuse treatment will require 20% coinsurance or equivalent copayment, reduced from the current 30—50% range.
- Opioid treatment programs will become fully covered with no cost-sharing, eliminating the current 50% coinsurance requirement.
- Inpatient psychiatric care cost-sharing will match Medicare Fee-For-Service rates exactly, rather than allowing up to 25% higher charges.

NBCC supports these changes in the proposed rule.

The changes are particularly significant because:

1. They represent one of the largest expansions of behavioral health access in MA history.
2. The elimination of cost-sharing for opioid treatment programs aligns with broader federal efforts to address the opioid crisis.
3. The standardization with Traditional Medicare rates helps prevent MA plans from using cost-sharing as a way to discourage enrollment by beneficiaries with behavioral health needs.

To address concerns about potential cost shifting, CMS emphasizes that existing laws and regulations prevent MA organizations from disproportionately increasing costs for specific beneficiary groups to offset behavioral health cost-sharing reductions.

Based on analyses detailed in section VII.E.3., CMS is proposing aligning MA behavioral health cost-sharing with Traditional Medicare rates starting in 2026. This approach aims to balance beneficiary costs with continued access to care and coverage options. The timing coincides with the final year of existing cost-sharing transition periods outlined in § 422.100(f)(6)(iii) and (f)(8). CMS believes the benefits of this new approach, which supports their broader behavioral health strategy, outweigh maintaining the current methodology.

The new rule makes it clearer that this is about:

1. Setting behavioral health cost-sharing limits in MA
2. Making these limits match Traditional Medicare
3. Implementing the change in 2026
4. Supporting broader behavioral health goals

This proposal is significant because it would ensure MA beneficiaries don't pay more for behavioral health services than Traditional Medicare beneficiaries, potentially improving access to mental health care.

This proposal also impacts Dual Eligible Special Needs Plan (D-SNP) PPOs in several ways:

- Starting in 2026, per § 422.100(o)(1), MA organizations offering local or regional PPO D-SNPs must limit out-of-network cost-sharing to match in-network service limits established for all MA plans under § 422.100(f)(6).
- Additionally, § 422.100(o)(2) requires D-SNP PPO out-of-network cost-sharing to align with in-network service limits set in § 422.100(j)(1), as established in the April 2024 final rule.
- CMS proposes to update the cross-reference in § 422.100(o)(2) from "excluding paragraph (j)(1)(i)(C)(2)" to "excluding the last sentence of paragraph (j)(1)(i)(C)" to maintain consistency with current rulemaking.

This change is significant because:

1. D-SNPs serve a vulnerable population (people eligible for both Medicare and Medicaid).
2. PPO plans typically have different cost-sharing for in-network versus out-of-network services.
3. This proposal helps ensure dual-eligible beneficiaries have consistent access to care regardless of network status.

CMS is proposing to align Cost Plan cost-sharing standards with MA plans for both behavioral health and non-behavioral health benefits. This proposal outlines:

- New in-network behavioral health service cost-sharing limits
- Expected impacts on 2026 plan cost-sharing across service categories

If implemented, CMS will track behavioral health service affordability and accessibility for MA enrollees, including analyzing utilization patterns through encounter data (as detailed in section III.L.e.(4)). These insights will guide understanding of service utilization trends and inform future regulatory decisions.

This proposal is significant because:

1. It standardizes cost-sharing across different Medicare plan types
2. It specifically addresses behavioral health access
3. It establishes a data-driven approach to monitoring outcomes
4. It creates a foundation for future policy adjustments based on utilization patterns

NBCC applauds CMS for developing this provision.

This Medicare regulation significantly impacts MHCs by establishing more equitable cost-sharing structures for behavioral health services. Under these provisions, MA plans and Section 1876 Cost Plans must ensure that cost-sharing for behavioral health services does not create financial barriers to mental health care access.

For MHCs, this rule:

- Expands the potential client base by making services more financially accessible to Medicare beneficiaries
- Reduces administrative burden related to collecting higher copayments and deductibles
- Creates more predictable revenue streams through standardized cost-sharing limits
- Potentially increases appointment adherence as patients face fewer financial obstacles
- Supports integrated care models by aligning behavioral health cost-sharing with primary care services

The rule particularly benefits MHCs serving Medicare-eligible populations in underserved communities, where cost barriers have historically limited access to mental health services. It also helps establish parity between mental health and physical health services, reinforcing the importance of behavioral health care in the overall health care system.

Improving Experiences for Dually Eligible Enrollees: Member ID Cards, Health Risk Assessments, and Individualized Care Plans (§§422.101, 422.107, 422.2267, 423.2267)

NBCC supports the proposed changes outlined by CMS to improve the overall experiences for dual eligibles. The Kaiser Family Foundation reports that 26% of dual eligibles have five or more chronic conditions, which demonstrates the unique needs of this population. We are optimistic that the proposed changes will promote better health outcomes and reduce costs.

Identification cards that note dual eligible status are a simple way to streamline processes for both beneficiaries and AIPs. With this single document, providers will immediately recognize dual-eligible status, reducing confusion and minimizing delays. Since Medicare and Medicaid differ in their coverage of mental and behavioral health services, NBCC believes that issuing these cards will help beneficiaries access the care they need without having to know which insurer is the primary insurer for specific services.

NBCC applauds CMS for proposing that AIPs conduct one Health Risk Assessment (HRA) for both Medicare and Medicaid. Currently, both Medicare and Medicaid plans require separate HRAs. This process can result in significant delays in mental and behavioral health care. NBCC believes that one HRA form will produce more accurate results and help patients and practitioners identify the correct mental or behavioral health service needed.

NBCC supports all of the proposed changes to the HRA and Individualized Care Plan (ICP) process that CMS outlines in the third part of this section.

The following changes are especially impactful for mental and behavioral health care:

- "Is person-centered and based on the enrollee's preferences, including for the delivery of services and benefits, and needs identified in the HRA;
- Is developed through an interdisciplinary care team with the active participation of the enrollee (or the enrollee's representative, as applicable), as feasible;
- Identifies person-centered goals and objectives (as prioritized by the enrollee), including measurable outcomes as well as specific services and benefits to be provided; and
- Is updated as warranted by changes in the health status or care transitions of enrollees"

NBCC firmly believes that engaging the enrollee and their representative is essential for developing more effective care plans. These plans will better reflect the patient and their unique needs and make it easier for providers to identify the type of care needed. NBCC appreciates the recognition that these ICPs can be improved.

Other Recommendations for CMS Consideration

Reimbursement Rates

NBCC is concerned about the low overall reimbursement rates that MA plans provide for mental health, behavioral health, and substance use disorder services. A report from the Department of Health and Humans Services in 2024 found that MA plans on average had just 4.7 mental health providers per 1,000 enrollees. While this number is higher than traditional Medicare, it is still shockingly low. NBCC strongly recommends that CMS explore ways to improve the reimbursement rate for mental health services as a way to increase the number of eligible providers. Many mental health professionals are unable to accept MA along with traditional Medicare because it is not financially feasible for them. We understand that reimbursement rate increases can be controlled by Congress, but CMS has tools such as the Physician Fee Schedule it can use to alleviate some of these challenges. MHCs and

many other mental health providers are interested in working with MA enrollees and are unable to. NBCC would be happy to continue to engage with CMS on reimbursement issues.

Key implications of these reimbursement issues for MHCs:

Financial Viability Challenges

- Current MA reimbursement rates make it financially unsustainable for many MHCs
- Forces difficult choices between accepting MA patients and maintaining practice viability
- May require supplementing MA practice with other revenue sources
- Creates barriers to serving Medicare populations despite willingness to do so

Access and Coverage Issues

- Severe shortage of providers (only 4.7 per 1,000 enrollees)
- Many MHCs who want to serve Medicare populations cannot afford to
- Creates access barriers for older adults and disabled populations
- Contributes to mental health treatment gaps in Medicare communities

Practice Management Implications

- Need to carefully evaluate whether accepting MA patients is financially viable
- May need to limit the number of MA clients to maintain practice sustainability
- Could require mixed-payment model to offset lower MA reimbursements
- Important to understand CMS fee schedule updates and implications

Workforce Development Impact

- Discourages MHCs from participating in Medicare networks
- May influence where MHCs choose to practice
- Could affect specialization decisions
- May limit professional growth opportunities in geriatric mental health

Medicare Advantage Network Adequacy Standards

In the Contract Year 2024 MA rule, CMS adopted new regulations (Behavioral Health Specialties in Medicare Advantage (MA) Networks [42 C.F.R. 422.112 and 422.116]) to allow MA plans to incorporate new behavioral health provider types into their networks for the purposes of network adequacy and evaluation: clinical social workers, clinical psychologists, and prescribers of opioid use disorder medications. In the Contract Year 2025 MA rule, CMS proposed to extend network adequacy requirements to MHCs and other behavioral health and substance use disorder providers and facilities by adding time and distance and minimum provider number requirements for a new combined provider category. CMS proposed a new Outpatient Behavioral Health (OBH) as a new type of facility-specialty in 42 C.F.R. 422.116(b)(2) and to add OBH to the time and distance requirements in 42 C.F.R. 422.116(d)(2).

We were pleased for the inclusion of MHCs for payment by MA plans. However, since most MHCs practice in a private practice setting, we found it noteworthy that MHCs were not individually added into the network adequacy standards as individual practitioners in 42 C.F.R. 422.116(a) as opposed to the facility-based network adequacy standards. According to recently released data from CMS, MA now provides Medicare coverage for over half of eligible beneficiaries. We wanted to take this opportunity to emphasize that with 54% percent of Medicare beneficiaries enrolled in MA plans—and this percentage will only grow in the coming decade—it is critically important to integrate MHCs into MA network adequacy rules as individual providers to expand access to mental health services for beneficiaries.

The purpose of legislation to expand Medicare payment to MHCs was to help lessen the shortage of behavioral health services afforded to Medicare beneficiaries. In connection with the Calendar Year 2024 Medicare Physician Fee Schedule rule, NBCC continues to recommend that CMS amend its regulations to fold MHC payment by

amending the network adequacy standards to provide that those that require contracting with clinical social workers could also have been met by contracting with MHCs. This would have helped MA plans with alternative contracting strategies that may generally be difficult to meet and should not have required the collection of new data. This would allow MHCs to ease widespread health care workforce shortages to expand beneficiary access to care.

We ask CMS—based on their collection of data in CY 2025—to update the standards as soon as possible to include MHCs as individual providers.

Key implications for MHCs include:

Medicare Access

- Currently, MHCs face barriers to providing services to Medicare beneficiaries.
- Including MHCs as individual providers in new standards would expand payment options for MHCs, potentially opening up a large new patient population.

Professional Parity

- Updating the standards would essentially put MHCs on equal footing with other mental health providers in MA networks.
- This would represent professional recognition of MHCs' qualifications and capabilities.

Business Opportunities

- MHCs could expand their practice to include MA patients.
- This could create new revenue streams and practice growth opportunities.
- MA plans would have more flexibility to contract with MHCs.

Workforce Impact

- The change would help address the behavioral health provider shortage.
- MHCs could fill crucial gaps in underserved areas.
- More Medicare beneficiaries would have access to mental health services.

Administrative Considerations

- The proposal wouldn't require new data collection systems.
- Implementation could be relatively straightforward since it would build on existing network adequacy standards.
- MA plans would have more flexibility in meeting their network requirements.

Thank you for your attention to these comments.

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

Sincerely,

Kylie Dotson-Blake