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Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1832–P
7500 Security Boulevard
Baltimore, MD 21244–1850

**RE: File Code CMS–1832–P (Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program)**

Dear Dr. Oz:

The National Board for Certified Counselors, Inc. and Affiliates (NBCC) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Medicare and Medicaid Programs.

NBCC provides national certification and the nationally normed examinations for state licensure for counselors. NBCC maintains standards and processes that ensure National Certified Counselors have achieved the highest standard of practice through education, examination, supervision, experience, and ethical guidelines. NBCC provides the examinations used for professional counseling licensure by all 50 states, Puerto Rico, Guam, and the Virgin Islands.

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

## I. Comments on Payment for Medicare Telehealth Services Under Section 1834(m) of the Social Security Act

### *Executive Summary*

NBCC strongly supports CMS's proposed telehealth policy changes, which represent significant improvements for mental health service delivery. As MHCs and marriage and family therapists (MFTs) have demonstrated exceptional success in providing telehealth services since becoming Medicare Part B providers in 2024, these proposals will enhance access, improve clinical outcomes, and support innovative service delivery models.

### a. Supporting CMS's Practitioner-Centered Approach

NBCC fully endorses CMS's recognition that practitioners are best positioned to determine whether services can be safely furnished via telehealth and whether telehealth provides clinical benefit. This approach is particularly appropriate for mental health services, where therapeutic relationships and clinical judgment are central to effective treatment.

MHCs possess specialized training in therapeutic relationship building, crisis assessment, and treatment planning that enables them to make informed decisions about telehealth appropriateness for individual patients.

Telehealth mental health services have proven particularly effective in overcoming traditional barriers to mental health care, including geographic barriers for beneficiaries in rural and underserved areas, transportation challenges common among older adults and disabled beneficiaries, mobility limitations that make office-based visits difficult, and stigma reduction through private home-based service delivery.

Research demonstrates that telehealth mental health services achieve clinical outcomes comparable to in-person services.

**b. Supporting the Streamlined Medicare Telehealth Services List Process**

NBCC strongly supports eliminating the provisional/permanent categorization and simplifying the review process. This approach reduces administrative burden by eliminating uncertainty about service permanency.

The simplified 3-step process should include mental health professional expertise. We recommend including mental health professionals in technical expert panels to ensure appropriate evaluation of behavioral health services.

**c. Strong Support for Adding Multiple-Family Group Psychotherapy (90849)**

We strongly support the inclusion of CPT code 90849 for telehealth. Multiple-family group psychotherapy represents an evidence-based intervention that is particularly well-suited for telehealth delivery. It provides several clinical advantages, including enhanced family engagement and development of mutual support networks. This service model provides intensive family intervention while serving multiple families simultaneously, improving access while managing costs.

Modern telehealth platforms are well-equipped with breakout room, screen sharing, and recording capabilities that support therapeutic assignments and skill practice between sessions with appropriate consent.

Telehealth delivery of multiple-family group psychotherapy particularly benefits rural families in areas that do not have clinicians readily available to provide care, caregiving families, and families with multiple scheduling constraints where coordinating in-person attendance across multiple family units is challenging.

Research indicates high satisfaction rates with telehealth family therapy services, particularly regarding convenience, reduced travel burden, and ability to receive services in comfortable, familiar environments (Bulkes et al., 2022).

**d. Support for Group Behavioral Health Counseling for Obesity (G0473)**

NBCC supports adding this service, as it incorporates significant behavioral health components that MHCs are qualified to provide. Group behavioral health counseling for obesity benefits from telehealth delivery through reduced stigma in that participants may feel more comfortable addressing weight-related issues from home, enhanced privacy in that private home environments may encourage more open discussion of eating behaviors and body image concerns, improved adherence in that convenience of telehealth delivery supports long-term participation in the required 12-month program, and family involvement in that telehealth enables family member participation in dietary and lifestyle planning.

**e. Strong Support for Permanent Direct Supervision via Audio/Video Technology**

The permanent adoption of audio/video direct supervision will enable enhanced training opportunities, including real-time supervision of MHCs in training, which is important for crisis intervention training and competency development; specialized treatment technique instruction; cultural competency and sensitivity training; and quality assurance and peer consultation.

This approach addresses the critical need for supervision in areas with limited mental health professional availability. Quality improvement applications include peer consultation on complex cases, real-time clinical support during challenging sessions, professional development and continuing education delivery, and best practice implementation and monitoring.

Audio/video supervision maintains appropriate clinical oversight while providing flexibility in service delivery.

**f. Supporting the Telehealth Originating Site Facility Fee Update**

NBCC supports the proposed 2.7% increase in the telehealth originating site facility fee to $31.85, which appropriately accounts for inflation and maintains the real value of this important access support. The originating site facility fee remains important for supporting mental health access in areas where patients may need to travel to access reliable internet and telehealth technology. This is particularly relevant for rural mental health centers that serve as originating sites for patients lacking reliable home internet, senior centers that provide technology support for older adults accessing telehealth mental health services, and community health centers that integrate mental health services with primary care through telehealth.

**g. Recommendations for Clinical Improvement Evidence**

CMS should recognize mental health–specific outcome measures when evaluating clinical improvement evidence for telehealth services. Suggested measures include standardized depression and anxiety scales such as PHQ-9, GAD-7, and other validated instruments.

Evidence demonstrates particular benefits for rural Medicare beneficiaries, including increased access with 40% improvement in mental health service utilization in rural areas, reduced travel burden, and improved treatment continuity (Barnett et al., 2021).
Research shows specific advantages for Medicare-age beneficiaries, including comfort and convenience through reduced anxiety associated with traveling, enhanced family participation in treatment planning, and chronic condition management through better integration of mental health services with overall health care management (Lyons & Andrews, 2023).

Telehealth mental health services provide particular benefits for disabled Medicare beneficiaries through accessibility improvements that eliminate physical barriers to mental health service access, assistive technology integration with compatibility for screen readers and other assistive technologies, and reduced physical demands through decreased fatigue and physical stress associated with health care visits.

**h. Additional Recommendations for Telehealth Enhancement**

We recommend proactively reviewing additional mental health services for telehealth appropriateness, including psychiatric diagnostic evaluation (90791) where comprehensive diagnostic assessments are effectively delivered via telehealth, individual psychotherapy with medical E/M (90834, 90837 with E/M) for combined mental health and medical management services, and crisis psychotherapy (90834, 90837 for crisis intervention) for emergency mental health interventions.

CMS should develop clear guidance and support including HIPAA compliance for secure telehealth platform selection and use, technology training telehealth competencies, and best practice guidelines.

We recommend supporting integration of outcome measurement tools with telehealth platforms to facilitate real-time assessment through administration of depression, anxiety, and other mental health screening tools during telehealth sessions, progress monitoring through longitudinal tracking of patient outcomes and treatment effectiveness, and quality reporting through simplified data collection for MIPS and other quality programs.

### *Conclusion*

CMS's telehealth proposals represent significant improvements that will enhance mental health service delivery for Medicare beneficiaries.

We encourage CMS to continue expanding telehealth opportunities for mental health services and to recognize the substantial clinical improvement evidence supporting telehealth mental health interventions.

## II. Comments on Advancing Access to Behavioral Health Services

### *Executive Summary*

NBCC strongly supports CMS's efforts to advance access to behavioral health services through clarification of Community Health Integration (CHI) and Principal Illness Navigation (PIN) services for MHCs and MFTs, expansion of Digital Mental Health Therapy (DMHT) payment policies, and consideration of additional digital health innovations. We provide specific recommendations to enhance these policies and ensure they effectively support comprehensive behavioral health service delivery.

### a. Supporting CHI and PIN Services Clarification for Mental Health Counselors

CMS's clarification that MHCs are included as "certified or trained auxiliary personnel" for CHI and PIN services represents a significant advancement in behavioral health integration. Counselors are uniquely positioned to provide these services, given their comprehensive training in psychosocial assessment, community resource coordination, and understanding of how social determinants impact mental health outcomes.

The clarification that MHCs can bill Medicare directly for CHI and PIN services they personally perform for mental health conditions recognizes their clinical expertise and statutory authority as Medicare Part B providers.

We support the requirement that auxiliary personnel performing CHI and PIN services under general supervision meet appropriate certification or training requirements when state-level requirements are absent. MHCs possess graduate-level training in assessment, treatment planning, and care coordination that exceeds typical auxiliary personnel qualifications, making them valuable contributors to CHI and PIN service delivery teams.

We have received comments from MHCs that they have encountered significant problems in receiving reimbursement for codes G0019 and G0022 due to current billing barriers.

**b. Strong Support for DMHT Payment Policy Expansion**

NBCC strongly supports CMS's proposal to expand payment policies for Digital Mental Health Therapy (DMHT) devices to include attention-deficit/hyperactivity disorder (ADHD) treatment. MHCs frequently treat patients with ADHD across the lifespan, and evidence-based digital interventions can significantly enhance traditional therapeutic approaches.

These tools provide continuous monitoring and intervention capabilities that extend therapeutic support beyond scheduled sessions.

MHCs trained in ADHD assessment and treatment are well-positioned to integrate these digital tools into comprehensive treatment plans that may include individual counseling, family therapy, behavioral interventions, and coordination with educational and occupational settings.

We recommend that CMS ensure adequate training and support resources are available to effectively integrate DMHT devices into practice. This should include guidance on patient selection criteria, integration with traditional therapeutic interventions, outcome measurement protocols, and coordination with other health care providers involved in ADHD treatment.

**c. Comments on Social Determinants of Health Risk Assessment Code Deletion**

While we understand CMS's rationale for proposing to delete HCPCS code G0136 for Social Determinants of Health Risk Assessment, we encourage careful consideration of the impact on behavioral health services. MHCs routinely assess social determinants as part of comprehensive mental health evaluations, as these factors significantly influence mental health outcomes and treatment planning.

If this code is deleted, we recommend that CMS ensure that evaluation and management codes adequately capture the time and complexity involved in comprehensive social determinants assessment. We also recommend that CMS consider developing alternative coding mechanisms that appropriately recognize the specialized assessment skills MHCs bring to identifying and addressing social determinants of mental health.

**d. Supporting Terminology Revision in Community Health Integration Services**

NBCC supports CMS's proposal to replace the term "social determinants of health" (SDOH) with "upstream drivers" in the Community Health Integration Services code (G0019). This may improve understanding and implementation of these important services while maintaining focus on the root causes of health disparities and poor health outcomes.

MHCs are particularly skilled at identifying and addressing upstream drivers of mental health problems. We recommend that CMS provide clear guidance on how this terminology change affects service delivery and documentation requirements to ensure continuity of care and appropriate billing practices.

## Digital Health Innovation and Mental Health Treatment

**1. Digital Tools for Mental Health Treatment Plans**

NBCC supports establishing coding and payment for digital tools used as part of mental health treatment plans; MHCs increasingly utilize digital tools to enhance treatment effectiveness, improve patient engagement, and extend therapeutic support between sessions.

Common tools include mood tracking applications, mindfulness and meditation apps, cognitive behavioral therapy (CBT) apps, sleep tracking tools that address sleep hygiene as part of mental health treatment, and communication platforms that facilitate secure messaging and crisis support.

Digital tools serve complementary roles in mental health care and are contingent on evidenced-based factors.

For pricing considerations, we recommend that CMS consider crosswalks with care management codes that reflect the ongoing monitoring and coordination involved in digital tool integration, psychotherapy codes when digital tools involve therapeutic content delivery, and technology-assisted treatment codes from other specialties that involve similar practitioner oversight and patient education components.

2. **Computerized Behavioral Therapy Devices**

We support consideration of establishing coding and payment policies for computerized behavioral therapy devices for gastrointestinal conditions, sleep disturbance in psychiatric conditions, and fibromyalgia symptoms.

MHCs frequently treat patients with these conditions as comorbid presentations with anxiety, depression, and other mental health disorders.

MHCs are trained in stress management, relaxation techniques, cognitive-behavioral interventions, and biofeedback approaches that align well with computerized behavioral therapy device applications. Payment policies for these devices would support comprehensive treatment approaches that address both psychological and physical symptom presentations.

3. **Software as a Service (SaaS) Payment Policy**

We support CMS's consideration of payment policies for software as a service (SaaS) applications in mental health treatment. SaaS platforms offer advantages such as continuous updates and improvements to therapeutic content, scalability to serve large patient populations, integration capabilities with electronic health records and outcome measurement systems, and cost-effectiveness compared to individual software purchases.

Payment policies for SaaS should consider the ongoing costs of platform access, training and technical support requirements, integration with existing clinical workflows, data security and HIPAA compliance features, and outcome measurement and quality reporting capabilities.

4. **Motivational Interviewing Coding and Payment**

NBCC strongly supports CMS's consideration of creating additional coding and payment for motivational interviewing, an evidence-based therapeutic approach widely used by MHCs. Motivational interviewing is particularly effective for addressing ambivalence about behavior change and is commonly used in mental health treatment for substance use disorders, health behavior modification, medication adherence, and treatment engagement.
MHCs receive specialized training in motivational interviewing techniques and utilize this approach across various clinical presentations.

We recommend that coding for motivational interviewing recognize both individual and group delivery formats, account for the specialized training requirements for effective implementation, and consider integration with other behavioral health interventions and care management activities.

5. **Eye-Tracking Technology for Autism Spectrum Disorder Diagnosis**

   MHCs work with individuals with autism spectrum disorder (ASD) and their families to address associated mental health challenges including anxiety, depression, social skills development, and behavioral interventions.

   We support the development of appropriate coding mechanisms for innovative diagnostic technologies that can improve accuracy and efficiency of ASD diagnosis.

   We recommend coding developed for eye-tracking technology include provisions for multidisciplinary team involvement.

**Recommendations for Implementation**

1. **Training and Technical Assistance**

   CMS should provide comprehensive training and technical assistance to help MHCs effectively implement these new services and technologies. This should include guidance on CHI and PIN service delivery and documentation requirements, training on digital therapy device integration and patient education, technical support for SaaS platform implementation and use, and continuing education on evidence-based applications of new technologies in mental health treatment.

2. **Quality Measurement and Outcomes**

   We recommend that CMS develop appropriate quality measures and outcome indicators for these new services that reflect the unique contributions of MHCs. These should include patient satisfaction and engagement measures, clinical outcome indicators specific to mental health conditions, quality indicators for care coordination and integration activities, and measures of access and utilization improvements.

3. **Integration With Existing Services**

   CMS should ensure that new coding and payment policies for digital health services integrate effectively with existing mental health service codes and payment structures. This includes avoiding duplication or conflicts with existing psychotherapy and evaluation codes, supporting coordinated care delivery across multiple providers and settings, and maintaining appropriate clinical oversight and supervision requirements.

***Conclusion***

MHCs are well-positioned to contribute to the above initiatives through their comprehensive training, clinical expertise, and commitment to addressing the full range of factors that influence mental health and well-being.

We encourage CMS to continue expanding recognition of MHCs’ role in integrated care delivery, digital health innovation, and evidence-based intervention implementation. These policies will support the nearly 60,000 MHCs now serving Medicare beneficiaries in providing comprehensive, innovative, and effective mental health services.

## III. Comments Supporting the 2026 Medicare Physician Fee Schedule Conversion Factor Structure

### *Executive Summary*

NBCC strongly supports the proposed dual conversion factor structure for the 2026 Medicare Physician Fee Schedule. This policy represents a meaningful step toward value-based care while providing essential payment increases for MHCs who became Medicare Part B providers in 2024. The differentiated conversion factors appropriately incentivize participation in alternative payment models (APMs) while ensuring all providers receive baseline payment increases.

### a. Significance for Mental Health Counselors

This structure provides crucial payment stability during this foundational period while establishing pathways for enhanced reimbursement through value-based care participation.

The qualifying APM participants will receive a 1.2% increase ($0.39 increase to $32.7365), which represents the larger payment adjustment for MHCs participating in qualifying APMs. Meanwhile, the nonqualifying providers will receive a 0.7% increase ($0.23 increase to $32.576), ensuring that all MHCs receive meaningful payment increases, even those not yet ready to participate in APMs. This baseline increase is particularly important for solo practitioners and small group practices that may need additional time to develop APM capabilities.

### b. Addressing Mental Health Access Challenges

Medicare beneficiaries face significant mental health challenges. The dual conversion factor structure supports improved access to mental health services. Payment increases help maintain and expand provider networks, addressing current workforce shortages. Enhanced payments for APM participants incentivize MHCs to engage in systematic quality improvement efforts, leading to better outcomes for Medicare beneficiaries. The APM payment differential also encourages mental health providers to adopt innovative service delivery models, including integrated care approaches and technology-enhanced interventions that can improve access and outcomes.

### c. Value-Based Care Alignment

The conversion factor differential appropriately recognizes that qualifying APM participants accept greater financial risk and accountability for patient outcomes. MHCs participating in APMs typically engage in enhanced quality reporting through systematic collection and reporting of mental health outcome measures, including standardized depression and anxiety screening tools, functional status assessments, and patient satisfaction metrics. They also participate in care coordination through active collaboration with primary care providers, psychiatrists, and other health care team members to ensure comprehensive, coordinated care for Medicare beneficiaries with mental health conditions.

APM participants take responsibility for population health management, managing the mental health needs of defined patient populations, including proactive outreach to high-risk beneficiaries and preventive mental health interventions. Additionally, they implement technology integration through electronic health records, patient portals, and other technologies that support care coordination and outcome measurement.

The modest differential between qualifying and non-qualifying conversion factors creates appropriate incentives without creating punitive disparities. This approach allows MHCs to build

capacity gradually by developing the infrastructure, technology, and administrative capabilities needed for successful APM participation without facing immediate financial penalties for nonparticipation. It enables them to learn from early adopters by observing and learning from mental health practices successfully participating in APMs before making their own transition. Most importantly, it allows providers to maintain financial stability by continuing to provide essential mental health services to Medicare beneficiaries while exploring APM opportunities.

**d. Supporting Practice Sustainability**

Mental health practices face unique financial challenges that make the conversion factor increases particularly important. Mental health services traditionally receive lower reimbursement rates compared to other medical specialties.

Meaningful payment increases support the mental health workforce in the following ways:

- Ensure that MHCs maintain competitive incomes.
- Support retention of experienced providers and recruitment of new professionals.
- Enable mental health practices to expand services, hire additional staff, and serve more Medicare beneficiaries.
- Support the development of specialized mental health services for Medicare beneficiaries, including geriatric mental health expertise and treatment of age-related conditions.

**e. Policy Recommendations**

For successful implementation, CMS should:

- provide guidance on APM qualification requirements and available programs suitable for mental health practices.
- offer technical assistance and resources to help mental health practices develop the capabilities needed for successful APM participation.
- develop mental health–specific outcome measures and quality indicators that accurately reflect the value MHCs provide to Medicare beneficiaries.
- consider gradually increasing the differential between qualifying and nonqualifying conversion factors over time as more mental health practices develop APM capabilities.
- develop APMs specifically designed for mental health services that recognize the unique characteristics of behavioral health care delivery.
- provide additional support for MHCs participating in integrated care models that coordinate behavioral health with primary care services.

***Conclusion***

The proposed dual conversion factor structure for 2026 represents sound policy that advances multiple important objectives: providing essential payment increases for MHCs serving Medicare beneficiaries, encouraging participation in value-based care models, and supporting the development of a robust mental health provider network for older adults. NBCC strongly supports this approach and encourages CMS to implement the proposed conversion factor structure as outlined.

## IV. Current Challenges in Mental Health Practice Expense Allocation

*Executive Summary*

NBCC urges CMS to reform Practice Expense Relative Value Unit (PE RVU) allocation methodologies to accurately reflect the unique characteristics of mental health counseling services, including extended session durations, specialized therapeutic environments, comprehensive technology infrastructure, crisis intervention capabilities, and collaborative care coordination activities that are inadequately captured in current methodologies.

### a. Unique Characteristics of Mental Health Practice

Mental health counseling services differ significantly from traditional medical services in ways that current PE RVU methodologies may not adequately capture. For example:

- Mental health counseling sessions typically last 45–60 minutes, compared to shorter medical visits. This extended time requirement affects both direct clinical labor costs and indirect expenses such as office space utilization and administrative overhead.
- MHCs often practice in specialized environments designed for therapeutic purposes, including soundproofed rooms, comfortable seating arrangements, and privacy-enhanced layouts that differ from standard medical examination rooms.

Modern mental health practice increasingly relies on specialized technology, including telehealth platforms, outcome measurement systems, electronic health records designed for behavioral health, and secure communication systems for crisis intervention. Mental health services require extensive documentation for treatment planning, progress notes, outcome measurement, and coordination with other providers, creating significant administrative labor costs that may not be fully captured in current PE RVU calculations.

### b. Facility vs. Non-Facility Allocation Issues

The current facility/non-facility PE RVU distinction may not adequately reflect the realities of mental health service delivery. MHCs provide services in various settings, including private offices, community mental health centers, integrated primary care practices, and telehealth environments. The binary facility/non-facility classification may not capture this diversity of practice arrangements.

### c. Recommendations for Improving Facility and Non-Facility PE RVU Allocation

- We recommend that CMS create specialized PE RVU categories that recognize the unique resource requirements of mental health services. Mental health counseling requires different inputs than traditional medical services, including specialized training for clinical staff, therapeutic environment modifications, and extended session durations that affect space utilization and overhead costs. Implementation should include conducting comprehensive practice expense surveys specifically targeting MHCs to gather accurate data on direct and indirect costs associated with different service settings.
- CMS should develop PE RVU allocations that appropriately account for technology infrastructure required for modern mental health practice. This includes telehealth platform costs and technical support, specialized software for outcome measurement and treatment planning, enhanced cybersecurity requirements for behavioral health data, and crisis intervention communication systems. Mental health services increasingly rely on technology to improve access, measure outcomes, and coordinate care, and current PE allocations may

undervalue these essential practice investments.PE RVU allocations should be adjusted to reflect the longer duration typical of mental health services. This methodology should weigh office space and administrative overhead costs based on actual session duration rather than standard medical visit assumptions, include pre- and post-session time required for mental health services such as treatment planning, documentation, and care coordination, and account for crisis intervention services that may extend beyond scheduled appointment times. CMS should develop PE RVU categories that recognize hybrid practice arrangements common in mental health, such as shared office arrangements with part-time space rental, integrated primary care settings where MHCs work within medical practices, and community-based settings including schools, community centers, and mobile crisis services.

**d. Alternative Approaches for Improving Indirect PE Allocation**

NBCC proposes implementing activity-based costing methodologies that more accurately capture the indirect costs associated with mental health service delivery. This approach should include administrative time for prior authorization and insurance verification; care coordination activities with primary care providers, psychiatrists, and social services; quality measurement and reporting activities; and professional development and supervision requirements.

CMS should include indirect costs associated with systematic outcome measurement and quality improvement activities. This includes staff time for administering and scoring mental health outcome measures, technology costs for outcome measurement platforms, administrative time for quality reporting and improvement activities, and training costs for implementing evidence-based measurement systems.

We recommend accounting for indirect costs associated with crisis intervention capabilities and safety protocols required in mental health practice. These elements include staff training for crisis intervention and suicide risk assessment, emergency contact systems and after-hours coverage arrangements, safety and security measures for therapeutic environments, and legal and ethical consultation services.

CMS should develop indirect PE allocations that support collaborative care arrangements between MHCs and other health care providers.

**<u>Data Collection and Validation Recommendations</u>**

NBCC recommends that CMS:

- conduct a specialized practice expense survey to gather accurate data on current practice costs. It should include detailed breakdown of direct and indirect costs by practice setting, technology and equipment costs specific to mental health services, administrative labor costs including care coordination and documentation, and space and facility costs for therapeutic environments.
- implement longitudinal tracking of mental health practice expenses to understand cost trends and adjust PE RVUs accordingly. Focus areas should include technology adoption and associated costs, changes in documentation and quality reporting requirements, evolution of telehealth and hybrid service delivery models, and impact of integrated care arrangements on practice costs.

- validate PE RVU calculations using multiple data sources, including professional associations, academic institutions, and health system partners. The methodology should compare survey data with actual practice financial statements, analyze cost data from different practice settings and geographic regions, and include input from mental health practice management experts and health care economists.

e. **Implementation Timeline and Support**

We propose a three-phase implementation approach.

- **Phase 1**: Focus on data collection during the first year, including launching a comprehensive mental health practice expense survey, conducting focus groups with MHCs in various practice settings, and analyzing existing PE RVU data for mental health services.
- **Phase 2**: Concentrate on methodology development during the second year, developing refined PE RVU allocation methodologies based on collected data, creating pilot programs testing new allocation approaches, and engaging stakeholders for feedback on proposed changes.
- **Phase 3**: Implement revised PE RVU allocations with appropriate transition periods during the third year, monitor impact on mental health provider participation and access, and establish ongoing data collection mechanisms for future adjustments.

***Conclusion***

Accurate PE RVU allocation is essential for ensuring that MHCs can maintain sustainable practices while serving Medicare beneficiaries.

NBCC strongly encourages CMS to implement the recommendations outlined above to improve both facility/nonfacility PE RVU allocation and indirect PE allocation methodologies.

We appreciate CMS's commitment to improving PE RVU methodologies and stand ready to collaborate on data collection, stakeholder engagement, and implementation efforts to ensure that mental health services receive appropriate valuation within the Medicare Physician Fee Schedule.

## V. Comments on Potentially Misvalued Services Under the PFS (Section II.C.)

***Executive Summary***

NBCC strongly supports CMS's robust process for identifying and reviewing potentially misvalued services, as well as the proposed updates to practice expense (PE) methodology that recognize greater indirect costs for office-based practitioners.

a. **Supporting the PMVC Review Process**

The PMVC review process is especially relevant for MHCs for several key reasons. Many of the assumptions underlying current Relative Value Units (RVU) assignments may not reflect actual practice patterns and resource requirements for MHCs and MFTs as new providers. Mental health service delivery has undergone significant transformation, including widespread adoption of telehealth, integration with primary care, and emphasis on measurement-based care approaches.

These factors collectively suggest that current RVU assignments for mental health services may not accurately reflect the contemporary reality of mental health counseling practice.

**b. Recommendations for Strengthening the PMVC Process**

NBCC recommends that CMS:

- conduct systematic review of psychotherapy codes (90834, 90837, 90847, 90853) to ensure RVU assignments reflect current practice patterns.
- review psychiatric diagnostic evaluation codes (90791, 90792) as provided by MHCs and assess crisis psychotherapy codes and their alignment with current crisis intervention practices.
- develop specialized data collection mechanisms that capture the unique characteristics of mental health service delivery.
- partner with mental health professional organizations to develop specialty-specific time and motion studies that accurately capture the full scope of MHC work. Reviews should account for the increasing integration of mental health services with primary care and other medical services.
- systematically review telehealth mental health services to ensure RVU assignments reflect actual work and practice expenses, including technology requirements and associated costs, pre-session preparation and troubleshooting time, enhanced documentation requirements for telehealth services, and crisis intervention protocols for remote service delivery.

**c. Supporting PE Methodology Updates**

NBCC strongly supports CMS's proposal to recognize greater indirect costs for practitioners in office-based settings, as this is particularly relevant for practitioners in office-based environments. Mental health practices face significant administrative overhead. Technology infrastructure, specialized practice environments, and care coordination costs are substantial. We recommend that CMS develop PE input categories that specifically capture mental health practice expenses including behavioral health EHR systems and specialized software, outcome measurement tools and licensing fees, crisis intervention communication systems, and professional liability insurance specific to mental health practice. Indirect cost allocation should be adjusted to reflect longer session durations typical in mental health.

CMS should include indirect costs associated with collaborative care arrangements.

**d. Nomination of Specific Mental Health Codes for PMVC Review**

We recommend these services for PMVC review:

- Psychotherapy services (90834, 90837) because current RVU assignments may not reflect the full scope of work involved in evidence-based psychotherapy delivery.
- Family psychotherapy (90847) because family therapy sessions involve additional complexity in managing multiple participants, enhanced treatment planning, and increased coordination requirements.
- Group psychotherapy (90853) because group therapy requires specialized skills, additional preparation time, and unique practice expenses that may not be adequately reflected in current valuations.
- Psychiatric diagnostic evaluation codes (90791, 90792) because comprehensive diagnostic evaluations by MHCs may involve different work patterns and resource requirements

compared to evaluations by other provider types. Mental health professional organizations have conducted extensive surveys of practice patterns, time requirements, and resource utilization that could support PMVC nominations. Peer-reviewed literature demonstrates changes in mental health practice patterns, technology adoption, and evidence-based treatment approaches that affect work intensity and resource requirements. Outcome measurement initiatives and quality improvement programs provide data on actual time and resource requirements for modern mental health practice. (Wiltsey Stirman, 2022).

**e. Implementation Recommendations**

NBCC recommends:

- establishing formal mechanisms for ongoing engagement with mental health professional organizations in the PMVC process through regular meetings with mental health specialty societies, technical expert panels including MHCs, and advisory groups to review mental health service valuations.
- development of a systematic timeline for reviewing mental health services over the next 3–5 years, with year 1 focused on reviewing primary psychotherapy codes and diagnostic evaluations, year 2 on family and group therapy services, year 3 on crisis intervention and specialized mental health services, and years 4–5 on ongoing maintenance and updates based on practice evolution.
- establishing ongoing data collection mechanisms specifically for mental health services, including regular practice expense surveys for mental health providers, time and motion studies for different types of mental health services, technology adoption tracking and cost analysis, and outcome measurement and quality reporting burden assessment.

***Conclusion***

The PMVC review process and PE methodology updates represent critical opportunities to ensure accurate valuation of mental health services within the Medicare program.

NBCC strongly supports CMS's commitment to identifying and correcting misvalued services and appreciates the agency's recognition that greater indirect costs for office-based practitioners need appropriate valuation.

We stand ready to provide detailed practice data, supporting documentation, and technical expertise to assist CMS in accurately valuing mental health services. Accurate service valuation is not merely a technical requirement—it is fundamental to ensuring access to mental health services for the millions of Medicare beneficiaries who depend on these essential health care services.

## VI. Comments on Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

***Executive Summary***

NBCC supports CMS's proposals to enhance behavioral health integration services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). We support the addition of behavioral health integration (BHI) and psychiatric Collaborative Care Model (CoCM) add-on codes, enhanced supervision flexibility, and improved care coordination recognition, while requesting clarification on MHC eligibility and expressing concerns about telehealth in-person visit requirements.

**a. Supporting Enhanced Behavioral Health Integration Services**

**Advance Primary Care Management (APCM) Services Enhancement**
NBCC supports CMS's proposal to adopt add-on codes for APCM that would facilitate billing for BHI and psychiatric CoCM services when RHCs and FQHCs are providing advanced primary care.

MHCs working in RHCs and FQHCs are uniquely positioned to provide BHI and psychiatric CoCM services due to their training in collaborative care models, expertise in brief intervention techniques, and understanding of population health approaches to mental health care.

The proposed add-on codes will help ensure that RHCs and FQHCs receive appropriate compensation for the additional resources and specialized staff required to implement effective BHI programs.

**Collaborative Care Model (CoCM) Implementation Support**
We support the proposal to require RHCs and FQHCs to report the individual codes that make up the CoCM HCPCS code G0512. This reporting requirement will provide valuable data on the specific components of collaborative care being delivered, supporting quality improvement initiatives and outcome measurement efforts.
The CoCM approach aligns well with MHCs' training in systems-based practice and their understanding of the importance of team-based care delivery.

**b. Supporting Care Coordination Service Recognition**

**Alignment with Physician Fee Schedule Care Management Services**
NBCC supports the proposal to adopt services that are established and paid under the PFS and designated as care management services as care coordination services for purposes of separate payment for RHCs and FQHCs.

MHCs in RHCs and FQHCs frequently provide extensive care coordination services, including communication with community mental health providers, coordination with social services and community resources, follow-up with patients between visits to support treatment adherence, and integration of behavioral health interventions with primary care treatment plans.

**c. Supporting Enhanced Supervision Flexibility**

**Audio/Video Direct Supervision Implementation**
NBCC strongly supports the proposal to adopt the definition of "immediate availability" as including real-time audio and visual interactive telecommunications for direct supervision permanently for all RHC and FQHC services. This enhancement is particularly important for mental health services in rural and underserved areas where experienced mental health supervisors may not be physically present at all service locations.

This supervision flexibility supports workforce development by enabling less experienced MHCs to work in underserved areas while receiving appropriate oversight, helping to address workforce shortages in rural and underserved communities

**d. Concerns About Telehealth In-Person Visit Requirements**

**Impact on Mental Health Service Access**
While we understand the legislative requirement for in-person mental health visit requirements,

we have significant concerns about the impact these requirements may have on mental health service access for vulnerable populations served by RHCs and FQHCs. The requirement for an in-person mental health service within 6 months prior to telecommunications services and at least every 12 months during ongoing telehealth care may create substantial barriers to care for patients in rural and underserved areas.

We appreciate that CMS has included flexibility allowing practitioners and patients to agree that risks and burdens outweigh benefits for particular 12-month periods with appropriate documentation. However, we encourage CMS to provide clear guidance on how this exception should be applied and to monitor the impact of these requirements on mental health service access and continuity.

**Recommendations for Implementation**

We recommend that CMS develop clear guidance for RHCs and FQHCs on implementing the in-person visit requirements in ways that minimize barriers to mental health care access. This should include guidance on appropriate documentation for exceptions, coordination with community partners to facilitate in-person visits when needed, and strategies for maintaining care continuity during transitions between telehealth and in-person services.

CMS should also consider the unique challenges faced by RHCs and FQHCs in implementing these requirements.

### e. Request for Clarification on Mental Health Counselor Eligibility

**Billing Authority for MHCs and MFTs**

NBCC requests clarification from CMS regarding whether MHCs can bill for the proposed APCM add-on codes, BHI services, CoCM services, and other care coordination services in RHCs and FQHCs. As Medicare Part B providers, MHCs and MFTs have statutory authority to provide mental health services, but the specific billing arrangements within RHC and FQHC payment models may require additional clarification.

We specifically request clarification on whether MHCs can serve as billing practitioners for BHI and CoCM add-on codes when they are the primary mental health professionals providing these services in RHC and FQHC settings, participate in collaborative care teams as care managers or behavioral health consultants with appropriate billing recognition, provide care coordination services that qualify for separate payment under the proposed care coordination service recognition, and supervise other mental health professionals providing services in these integrated care models.

### f. Comments on Care Coordination Service Alignment

**Supporting Sustainable Implementation**

We support the proposed process to align care coordination services with care management services paid under the PFS and believe this approach provides a sustainable framework for recognizing the valuable care coordination work performed in RHCs and FQHCs. This alignment helps ensure consistency across different health care settings and provides clear guidance for billing and payment of these important services.

MHCs in RHCs and FQHCs perform extensive care coordination activities.

The proposed alignment with PFS care management services will help ensure that these activities receive appropriate recognition and payment. We recommend that CMS continue to monitor the effectiveness of this approach and consider adjustments as needed to ensure that care coordination services are adequately valued and that RHCs and FQHCs can maintain robust behavioral health integration programs.

**Recommendations for Improvement**
To improve transparency and efficiency for RHCs and FQHCs, we recommend that CMS provide regular updates and clear guidance when new care management services are established under the PFS, develop standardized reporting mechanisms that facilitate adoption of new care coordination codes, and create educational resources to help RHCs and FQHCs understand and implement new care coordination service requirements.

We also recommend that CMS consider the unique characteristics of RHCs and FQHCs when developing care coordination service policies.

### g. Implementation Support Recommendations

**Training and Technical Assistance**
CMS should provide comprehensive training and technical assistance to help RHCs and FQHCs successfully implement the proposed behavioral health integration enhancements.

**Quality Measurement and Monitoring**
We recommend that CMS develop appropriate quality measures and monitoring mechanisms to assess the impact of these proposals on behavioral health service access and outcomes.

***Conclusion***

CMS's proposals for RHCs and FQHCs represent important steps toward enhancing behavioral health integration and improving mental health service access in underserved areas.
These proposals have the potential to significantly enhance MHCs' ability to deliver effective, integrated behavioral health care, and we appreciate CMS's recognition of the importance of behavioral health integration in comprehensive primary care delivery.

## VII. Comments on Medicare Shared Savings Program

***Executive Summary***

NBCC supports CMS's proposed changes to the Medicare Shared Savings Program that enhance behavioral health integration within Accountable Care Organizations (ACOs). The proposals to include behavioral health integration and psychiatric collaborative care management add-on services in primary care services for beneficiary assignment purposes and to rename the "health equity benchmark adjustment" to the "population adjustment" to better reflect adjustments for vulnerable populations recognize the critical role that MHCs play in comprehensive, coordinated care delivery.

### a. Supporting Behavioral Health Integration in ACOs

CMS's proposal to include behavioral health integration and psychiatric collaborative care management add-on services when furnished with advanced primary care management services in the definition of primary care services for beneficiary assignment represents an important step toward recognizing MHCs' contributions to integrated care models.

This change appropriately acknowledges that behavioral health services are integral components of comprehensive primary care and should be recognized in ACO assignment methodologies.

**Supporting Population-Based Adjustments**

The proposal to rename the "health equity benchmark adjustment" to the "population adjustment" more accurately reflects the nature of the adjustment which accounts for the proportion of an ACO's assigned beneficiaries who are enrolled in the Medicare Part D low-income subsidy or dually eligible for Medicare and Medicaid. MHCs frequently serve these vulnerable populations and understand the complex social and economic factors that affect health outcomes.

### b. Recommendations for Mental Health Counselor Integration

CMS should clarify how MHCs can participate in ACOs and contribute to shared savings achievements. As Medicare Part B providers, MHCs should be eligible to participate as ACO providers and contribute to quality measure achievement and cost savings initiatives.

***Conclusion***

These Medicare Shared Savings Program proposals support the integration of behavioral health services within coordinated care models and recognize the importance of serving vulnerable populations. MHCs stand ready to contribute to ACO success through their expertise in integrated care delivery, population health management, and addressing the behavioral health needs of Medicare beneficiaries. With 477 ACOs serving over 11.2 million Medicare beneficiaries, ensuring that MHCs can fully participate in these arrangements will help achieve better outcomes for Medicare beneficiaries while supporting cost-effective care delivery.

## VIII. Recommendations for Mental Health-Specific Considerations

***Executive Summary***

NBCC urges CMS to adapt the Quality Payment Program (QPP) to recognize the unique characteristics of mental health counseling practice by:

- developing behavioral health–specific quality measures including standardized mental health outcome tools.
- measurement implementation, collaborative care participation, and evidence-based psychotherapy training.
- addressing unique interoperability challenges in behavioral health.
- creating alternative payment model opportunities designed for behavioral health services
- providing comprehensive implementation support for MHCs as new Medicare providers.

### a. Quality Measures for Mental Health Services

CMS should develop and include quality measures that accurately reflect the value and outcomes of mental health counseling services. These measures should include standardized mental health outcome measures such as depression and anxiety screening tools (PHQ-9, GAD-7), functional status and quality of life assessments, treatment engagement and retention metrics, and crisis prevention and safety measures.Mental health quality measures should recognize the longer-term nature of mental health treatment outcomes and the importance of patient-centered goals and recovery-oriented approaches.

b. **Improvement Activities Relevant to Mental Health Practice**

The improvement activities performance category should include activities specifically relevant to mental health counseling practice, such as implementation of systematic outcome measurement in mental health treatment, participation in collaborative care models and behavioral health integration initiatives, training in evidence-based psychotherapy approaches and trauma-informed care, and engagement in suicide prevention and crisis intervention training.

c. **Promoting Interoperability for Behavioral Health**

The promoting interoperability performance category should recognize the unique technology requirements and challenges in mental health practice. This includes electronic health record systems designed for behavioral health documentation requirements, outcome measurement platforms and integration with clinical workflows, secure communication systems for crisis intervention and patient engagement, and telehealth technology supporting mental health service delivery. MHCs may face different interoperability challenges compared to other medical specialties.

d. **Supporting Alternative Payment Model Participation**

NBCC supports CMS's efforts to align MIPS and APM tracks and create meaningful participation opportunities for MHCs.

MHC participating in integrated primary care settings, collaborative care models, and accountable care organizations can contribute meaningfully to APM objectives while maintaining their focus on evidence-based mental health treatment and patient-centered care approaches.

e. **Implementation Support for New Medicare Providers**

CMS should provide comprehensive education and technical assistance on QPP participation. This should include guidance on MIPS participation requirements and reporting mechanisms, training on quality measure selection and data collection for mental health services, technical support for implementing interoperability requirements in behavioral health settings, and resources for identifying and participating in relevant APM opportunities.

We recommend that CMS consider a gradual implementation approach for newly eligible mental health professionals, similar to approaches used for other new Medicare provider types, to ensure successful transition into the Quality Payment Program.

*Conclusion*

The Quality Payment Program represents an important opportunity to recognize and reward high-quality mental health care delivery while supporting continuous improvement in behavioral health services. MHCs are committed to participating meaningfully in QPP initiatives and contributing to improved outcomes for Medicare beneficiaries with mental health needs.

NBCC looks forward to working with CMS to ensure successful implementation of QPP policies for MHCs and to supporting the integration of behavioral health quality measures and improvement activities into the broader Medicare quality framework.

Thank you for your attention to these comments.

If you have further questions, please contact

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