nbcc
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BY ELECTRONIC DELIVERY

September 2, 2022

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Ms. Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-2022-0113 - Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts

Dear Secretary Becerra and Administrator Brooks-LaSure:

The National Board for Certified Counselors, Inc. (NBCC) thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to provide comments on the CY 2023 Physician Fee Schedule proposed rule. NBCC is the national credentialing organization for the counseling profession, representing over 68,000 National Certified Counselors[1] in the United States, with a goal of advancing mental health services across the globe. NBCC supports CMS' proposal to expand the utilization of licensed professional counselors (LPCs) in the proposed rule, as the change will improve access to critical behavioral health services at a time when there is increased demand for services and workforce shortages in behavioral health.

NBCC is an independent, not-for-profit that develops and administers the examinations for licensure of mental health counselors (MHCs) in all 50 states, Puerto Rico, the District of Columbia, and the US Virgin Islands. Board certification of MHCs, including the required national examination, ensures that counselors have met high national standards for counseling and provides peace of mind to referring providers and the public. We are passionate about

[1] National Board for Certified Counselors. *About Us*. Accessed August 2022 at https://www.nbcc.org/about.

supporting counselors and mental health providers, reducing stigma surrounding mental health, and expanding mental health services to underserved areas and populations.

NBCC greatly supports the efforts CMS has taken so far to improve access to and quality of mental and behavioral health care services through the 2022 CMS Behavioral Health Strategy, including this proposed rule. We strongly agree with CMS' statement in the proposed rule that reducing barriers and making greater use of LPCs is critical to CMS' strategy of helping to reduce workforce shortages and ensuring Medicare patients are receiving the mental and behavioral health care they need. In addition, we also believe ensuring that MHCs can practice to the fullest extent possible by amending the direct supervision of a physician or non-physician practitioner (NPP) requirement under the 'incident to" regulation is an essential step forward. We urge CMS to ensure that this provision makes it into the final Physician Fee Schedule rule to improve access to mental and behavioral health treatments for millions of Medicare beneficiaries.

Trends in Behavioral Health Demand and Provider Shortages

In the proposed rule, CMS recognizes the high demand for behavioral health services and the shortage of behavioral health providers our country is currently facing, which has only been exacerbated by the opioid epidemic and COVID-19 pandemic. In 2020, the most recent data available, 21 percent (or 52.9 million) adults aged 18 or older had any mental illness (AMI), with adults aged 50 or older making up 14.5 percent (or 16.9 million) of individuals with AMI.[2] Nearly 31 percent (16.1 million) of all adults reporting an AMI in 2020 reported a perceived unmet need for mental health services, with over 20 percent (or 3.4 million) of those adults being aged 50 or older.[3] Both AMI and perceived unmet need for mental health services have trended upwards over the past several years.

This trend also holds true for substance use disorders (SUD). In 2020, nearly 15 percent (or 40 million) of individuals aged 12 or older had an SUD, with 14 percent (or 30.5 million) of those adults aged 26 or older.[4] For individuals who perceived needing SUD treatment but who did not receive treatment, over 14 percent stated it was because they were unable to find a program that offered the type of treatment they wanted.[5] Unfortunately, access to mental health care and SUD treatment services have not kept pace with demand due to workforce shortages, particularly in rural areas.

[2] Substance Abuse and Mental Health Services Administration. (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/.

[3] Ibid.

[4] Ibid.

[5] Ibid.

According to the Health Resources & Services Administration (HRSA), 155 million people in the United States (US) live in Mental Health Professional Shortage Areas.[6] It is estimated that the country will be short between 14,280 and 31,109 psychiatrists,[7] and psychologists, school psychologists, and social workers will be overextended as well. The access and need gaps are wider in rural areas, where it is estimated that as many as 65 percent of nonmetropolitan counties do not have a psychiatrist.[8]

Insufficient Number of Geriatric-Specialized Professionals in Behavioral Health

Medicare has seen a dramatic increase in the number of beneficiaries presenting with mental or behavioral health diagnoses. Aging is often associated with unique challenges that can negatively impact mental health, such as the increased burden of illness, loss of social support, and functional decline.[9] In addition, about one-fifth of Medicare beneficiaries live in rural areas,[10] where access to any type of health service can be more difficult. Medicare has been unable to handle the increased need for older adult mental health services, as the number of psychiatrists accepting Medicare has declined over time,[11] with less than 1,300 geriatric psychiatrists active in the US.[12] This has created access issues for beneficiaries, particularly access to in-network mental health providers.

The ongoing opioid crisis is also a major concern in Medicare, as it has impacted rural America particularly hard. The inadequate coverage of SUD providers by Medicare has only served to fuel this public health disaster. A July 2017 Inspector General's report found that 500,000 Medicare Part D recipients received high amounts of opioids, and almost 90,000 were deemed at serious risk of opioid misuse or overdose.[13] Opioid misuse or abuse can lead to further health-related risks, particularly for seniors, where long-term use or abuse can increase the

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[6] Health Resources & Services Administration. *Health Workforce Shortage Areas Dashboard.* Updated August 25, 2022. Accessed on August 26, 2022 at https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[7] Satiani A, Niedermier J, Satiani B, Svendsen DP. Projected Workforce of Psychiatrists in the United States: A Population Analysis. *Psychiatr Serv*. 2018;69(6):710-713. doi:10.1176/appi.ps.201700344.

[8] Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. Geographic variation in the supply of selected behavioral health providers. *American Journal of Preventive Medicine* 2018; 54(6, Suppl. 3): S199–S207. doi: 10.1016/j.amepre.2018.01.0047.

[9] Koenig HG, George LK, Schneider R. Mental health care for older adults in the year 2020: a dangerous and avoided topic. *Gerontologist*. 1994;34(5):674-679. doi:10.1093/geront/34.5.674.

[10] MedPAC. *A Data Book: Health Care Spending and the Medicare Program*. Published July 2021. Accessed on August 26, 2022 at https://www.medpac.gov/wp-content/uploads/2021/10/July2021_MedPAC_DataBook_Sec2_SEC.pdf.

[11] Bishop TF, et al., Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care. *JAMA Psychiatry* 71, no. 2 (Feb. 2014): 176–81.

[12] University of Michigan Behavioral Health Workforce Research Center. Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. Ann Arbor, MI: UMSPH; 2018.

[13] *Opioids in Medicare Part D: Concerns About Extreme Use and Questionable Prescribing*, U.S. Department of Health & Human Services, Office of the Inspector General, July 2017.

likelihood of falls and fractures.[14] As the baby boomer generation continues to move toward retirement, Medicare will continue to see increases in mental health conditions and SUD disorders among its beneficiaries, requiring more workforce needs. MHCs are ready to fill these treatment gaps.

MHCs Can Fill the Mental and Behavioral Health Service Gaps in Medicare

MHCs are licensed to provide the same psychotherapy services as other mental health providers that are covered under Medicare Part B in all 50 states and in a variety of settings. MHCs must obtain, at a minimum, a master's degree; perform two years of postgraduate clinical supervised experience; and pass a national exam to practice independently. They can work in clinics, hospitals, private practice, mobile response teams, mental health institutions, and other settings. These requirements mirror those of current Medicare mental health providers, such as licensed clinical social workers. Eliminating the requirement that a physician must be physically present to supervise mental health counselors will expand access to over 140,000 MHCs nationwide.[15]

Research shows that MHCs are much more likely to be in rural areas than any other mental or behavioral health practitioner. There are over twice as many counselors in rural counties as social workers, six times the number of psychologists, and thirteen times the number of psychiatrists.[16] Therefore, MHCs are easily accessible and ready to serve Medicare beneficiaries to the fullest extent of their licenses and we appreciate CMS' acknowledgment of that fact in the proposed rule.

We also acknowledge that CMS does not have the authority to allow for the coverage of additional practitioner types in the Physician Fee Schedule. MHCs are not currently recognized providers under Medicare. We encourage CMS to consider other opportunities to increase the utilization of MHCs in certain settings in the Medicare program. NBCC is currently advocating for the passage of S. 828/H.R. 432, the Mental Health Access Improvement Act, which would allow MHCs to bill Medicare Part B and further improve access to care for Medicare beneficiaries.

MHCs Serving Dual-Eligible Individuals

We applaud CMS for its active role in improving health outcomes for individuals that are dually eligible for Medicare and Medicaid. Dual eligible individuals suffer from mental health conditions at a much higher rate than the larger Medicare population, with 64 percent of full dual

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[14] Saunders KW, Dunn KM, Merrill JO, et al. Relationship of opioid use and dosage levels to fractures in older chronic pain patients. *J Gen Intern Med*. 2010;25(4):310-315. doi:10.1007/s11606-009-1218-z.

[15] Health Resources and Services Administration. Behavioral Health Workforce Projections. Updated August 2022. Accessed August 2022 at https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/ behavioral-health.

[16] Larson EH, Patterson DG, Garberson LA, Andrilla CHA. Supply and Distribution of the Behavioral Health Workforce in Rural America. Data Brief #160. Seattle, WA: WWAMI Rural Health Research Center, University of Washington, Sep 2016.

beneficiaries reporting a mental or behavioral health diagnosis.[17] Behavioral health is often carved out of state Medicaid managed care programs, creating barriers to coordinating physical and behavioral healthcare. MHCs are covered providers in the vast majority of state Medicaid programs and provide services to Medicaid beneficiaries in a variety of settings. Therefore, while MHCs are legally able to treat dual eligibles and bill the Medicaid program, they are often unable to obtain the coverage denial letter necessary to bill Medicaid as the secondary insurance. It is our understanding that since MHCs are not eligible Medicare providers, CMS is generally unable to issue a denial letter. NBCC urges CMS to issue clarification confirming that MHCs are able to bill Medicaid for services, as a secondary insurance to Medicare, when treating dual-eligible individuals.

Conclusion

Thank you for the opportunity to provide comments on CMS's Physician Fee Schedule proposed rule. Mental and behavioral health issues are on the rise in the United States, and although improved treatment methods, early diagnosis, and decreased stigma are improving outcomes, there are millions of individuals who are not receiving the care they need. Improving access to mental and behavioral health services in Medicare by allowing these services to be furnished by LPCs will greatly extend the reach of services to the millions of seniors in the US that need them. Should you have any questions, please feel free to contact me at dotson-blake@nbcc.org or 336.500.1577.

Sincerely,

Kylie P. Dotson-Blake PhD, NCC, LCMHC

President and CEO

National Board for Certified Counselors

[17] ATI Advisory and Arnold Ventures. *A Profile of Medicare-Medicaid Dual Beneficiaries*. Published June 2022. Accessed August 2022 at https://atiadvisory.com/wp-content/uploads/2022/06/A-Profile-of-Medicare-Medicaid- Dual-Beneficiaries.pdf.