American Counseling Association

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September 7, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
ATTN: CMS–1784–P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: [CMS-1784-P] Medicare Program; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; et al.

Dear Administrator Brooks-LaSure:

The American Counseling Association ("ACA") appreciates the opportunity to comment on the Physician Fee Schedule (PFS) proposed rule for calendar year (CY) 2024.[1] ACA is a not-for-profit, professional and educational organization dedicated to the growth and enhancement of the counseling profession. Founded in 1952, ACA is the world's largest association exclusively representing professional mental health counselors (MHCs),[2] with most of its approximately 60,000 members practicing in the United States. We appreciate CMS' recognition of the important role these highly trained professionals play in the nation's health services delivery system.

MHCs provide care and treatment for mental health and substance use disorders to millions of Americans. States' licensure requirements for MHCs typically include:

- Possession of a master's or doctoral degree in counseling from a national or regionally accredited institution of higher education, including an internship and coursework on the etiology of mental illness and SUDs, effective treatment and counseling strategies, ethical practice, and other core knowledge areas;

[1] 88 Fed. Reg. 52262 (Aug. 7, 2023).

[2] States identify Licensed Professional Counselors by various titles; *e.g.*, "Licensed Mental Health Counselor," "Licensed Clinical Professional Counselor," "Licensed Professional Clinical Counselor Mental Health," "Licensed Clinical Mental Health Counselor," "Licensed Mental Health Practitioner," or "Licensed Mental Health Practitioner." American Counseling Association, Credentials and Titles. For purposes of this comment letter, we use the term "Mental Health Counselor," which is consistent with the new benefit category established by Section 4121 of the Consolidated Appropriations Act, 2024 (CAA 2024) and this proposed rule.

- Passage of the National Counselor Examination (NCE) administered by the National Board for Certified Counselors or a similar state-recognized exam;
- Completion of a minimum of 2,000 to 3,000 hours of post-master's degree supervised clinical experience, performed within a certain time period, including a specific number of face-to-face supervision hours;
- Adherence to a strict Code of Ethics and recognized standards of practice, as regulated by a state's counselor licensure board; and
- Periodic completion of continuing education credits/hours after obtaining licensure to remain current in their practice field.

ACA appreciates the agency's commitment to effective implementation of the *Mental Health Access Improvement Act*, which passed as part of the *Consolidated Appropriations Act of 2023* (CAA, 2023; Pub. Law 117-328) and the agency's leadership in implementing its comprehensive Behavioral Health Strategy to address the mental health crisis continuing to impact our nation. These actions will significantly enhance the ability of MHCs to provide quality mental health and SUD services to Medicare beneficiaries. **We specifically commend CMS for proposing the following in the proposed rule:**

- Providing flexibility with respect to satisfying clinical supervision requirements for MHC eligibility;
- Recognizing MHCs as eligible telehealth practitioners;
- Recognizing MHCs' use of diagnostic tests;
- Allowing Addiction Counselors who meet education and training requirements to participate in the Medicare program as MHCs;
- Allowing MHCs and Marriage and Family Therapists (MFTs), as well as Clinical Psychologists (CPs) and Clinical Social Workers (CSWs), to bill for General Behavioral Health Integration (BHI) services; and
- Allowing CSWs, MFTs, and MHCs to bill for Health Behavior Assessment and Intervention Services (HBAI) services.
- Permitting MFTs and MHCs to furnish Part B services at Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

As discussed below, we also believe it is important for CMS to make clear that MHCs may provide and be reimbursed for Mobile Crisis Team (MCT) services furnished to beneficiaries and for CMS to provide additional information on the Merit-Based Incentive Payment System (MIPS). We describe our feedback on specific provisions in the proposed rule in greater detail below.

Eligible Practitioners

ACA appreciates CMS' proposed post-graduate clinical supervision requirements for MHCs to be eligible to enroll in Medicare. In particular, CMS proposes that MHCs perform at least two years *or 3,000 hours* of post-master's degree clinical supervised experience in an appropriate setting, such as a hospital, Skilled Nursing Facility (SNF), private practice, or clinic, "if consistent with State licensure requirements." We appreciate the proposed flexibility and agree that 3,000 hours is an appropriate proxy for the two-year requirement in the statute. This proposal, if

finalized, would enable participation in Medicare of MHCs who complete 3,000 hours of supervision in less than two years, which aligns with some existing state licensure requirements. For instance, Mississippi, Montana, Utah, and Virginia require 3,000 hours of post-master's degree clinical supervised experience but fewer than two years. Maximizing the number of Medicare-eligible MHCs would increase Medicare beneficiaries' access to behavioral health services and ensure greater continuity of care for beneficiaries whose MHCs are authorized to practice sooner than two years of supervision. We also agree with CMS that the proposed regulation defining eligibility should align with the requirements for CSWs at § 410.73(a)(3)(ii), which allow two years or 3,000 hours of supervised experience.

ACA notes that Montana and Utah do not require all years or hours of post-master's degree clinical supervised experience to be completed after receiving a master's degree. Montana requires half the required years to be completed, and Utah requires at least 1,000 hours. We believe CMS should allow additional flexibility for practitioners in these states consistent with their licensing laws so that such MHCs can enroll in Medicare to ensure uniform access to mental health diagnostic and treatment services for Medicare beneficiaries across states. Please see below for additional information on State licensure requirements.

States that require fewer than 3,000 hours of post-degree clinical supervised experience (excludes practicum and internship hours)

- **Georgia:** 2,000 hours and at least two years
- **South Dakota:** 2,000 hours and at least two years
- **South Carolina:** 1,500 hours and at least two years
- **Rhode Island:** 2,000 hours and at least two years
- **Oregon:** 1,900 hours and at least two years
- **Minnesota:** 2,000 hours and less than two years (for LPC); 4,000 hours and at least two years (for LPCC)
- **Maine:** 2,000 hours and at least two years (for LPC); 3,000 hours and at least two years (for LCPC)
- **Idaho:** 1,000 hours and less than two years (for LPC); 2,000 hours and at least two years (for LCPC)
- **Florida:** 1,500 hours and at least two years
- **Colorado:** 2,000 hours and at least two years

States that require fewer than two years of post-degree clinical supervised experience:

- **Mississippi:** 3,000 hours and less than two years
- **Montana:** 3,000 hours and less than two years
- **Utah:** 3,000 hours and less than two years
- **Virginia:** 3,400 hours and less than two years

States that do not require all years/hours of clinical supervised experience to be completed after earning a master's degree:

- **Montana:** Half of the years must be post-master's
- **Utah:** At least 1,000 hours have to be post-master's

States that do not require all hours of post-master's degree clinical supervised experience to be completed under an instructor's direct supervision:

- **Alabama:** Only 2,500 hours need to be direct
- **Alaska:** Only 1,000 hours need to be direct
- **Kansas:** Only 1,500 hours need to be direct
- **Virginia:** Only 2,000 hours need to be direct

For the past four years, ACA has worked with the Council of State Governments and the National Center for Interstate Compacts to create and operationalize an interstate compact for counselors. The Counseling Compact, expected to become operational in mid-2024, is an agreement among states to recognize other states' counseling licenses legally, resulting in reciprocal licensure beyond the MHC's home state. Twenty-nine states have now passed the Compact legislation, and a Counseling Compact Commission has officially formed, for which each participating state has appointed a commissioner. The Compact legislation requires the Commission to establish a uniform supervised post-graduate professional experience requirement, which is likely to promote additional uniformity across states with respect to licensure requirements. While ACA recognizes that Medicare provider eligibility criteria need not precisely align with state or Compact licensure requirements, we hope that CMS will consider the Commission's post-graduate experience requirements relevant to future rulemaking.

Telehealth

ACA appreciates CMS's proposal to recognize, consistent with the CAA, 2023, MFTs and MHCs as telehealth practitioners effective January 1, 2024. Doing so would allow MHCs to continue practicing as they have been and not disrupt the provision of behavioral health care, which can be safely delivered using two-way interactive audio-video communications technology. Indeed, Medicare beneficiaries can benefit from receiving such services in this manner and some feel more comfortable discussing and receiving part of their treatment for their behavioral health condition(s) via telehealth rather than in person. ACA has found that the ability to furnish telehealth services increases participation in counseling and removes certain barriers hindering patients' access to care, the latter of which is especially necessary for Medicare beneficiaries with mobility and/or transportation issues. Allowing MHCs to furnish telehealth services also expands the availability of specialized services that may not be offered near a patient, which is particularly important when a patient's condition requires specialized treatment. Furthermore, many MHCs already provide telehealth regularly.

Diagnostic Tests

ACA appreciates CMS' proposal to amend the regulation at 42 C.F.R. § 410.32(a) to include MHCs on the list of practitioners who can order diagnostic tests, to the extent State law allows. We agree with CMS' reasoning to expand the list given that CSWs and CPs are included. Diagnostic tests help MHCs provide accurate diagnoses quicker, resulting in earlier intervention and faster delivery of treatment. MHCs use diagnostic tests as part of their everyday practice.

Addiction Counselors

Counselors specializing in substance use disorders play a key role in communities nationwide. We appreciate CMS's proposal to allow Addiction Counselors who meet all the proposed eligibility requirements for MHCs to also enroll in Medicare as MHCs. With nearly twenty percent[3] of people over sixty-five years old in the United States battling a chemical dependency, CMS' proposal will increase Medicare beneficiaries' access to mental health and addiction expertise.

General Behavioral Health Integration (BHI) Services

ACA thanks CMS for proposing to revise the code descriptor for HCPCS code G0323 to allow MHCs and MFTs, as well as CPs and CSWs, to bill for General Behavioral Health Integration (BHI) services as part of a primary care team. ACA requested this descriptor change in a meeting with CMS in March 2023. To report the HCPCS code, MHCs and MFTs must spend at least twenty minutes per calendar month providing BHI services that include the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners whom Medicare authorizes to prescribe medications and furnish evaluation and management (E/M) services, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

ACA and its members recognize that integrated care improves patient health outcomes.[4] We appreciate CMS' efforts to ensure that MHCs and MFTs can bill for important beneficiary services such as those provided under G0323, along with the CPs and CSWs currently eligible to bill for these services.

Health Behavior Assessment and Intervention (HBAI) Services

ACA commends CMS for proposing to allow CSWs, MFTs, and MHCs, in addition to CPs, to bill for Health Behavior Assessment and Intervention (HBAI) services, which ACA requested in our meeting with CMS in March 2023. HBAI CPT codes (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, and 96171) are used for the psychological assessment and treatment of a patient whose primary diagnosis is a medical condition. The HBAI codes capture services related to physical health, such as adherence to medical treatment, symptom management, health-promoting behaviors, health-related risky behaviors, and adjustment to physical illness.

As permitted under State law and their scope of practice, MHCs routinely provide HBAI services.

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[3] https://www.addictioncenter.com/addiction/elderly/.

[4] https://integrationacademy.ahrq.gov/about/integrated-behavioral-health.

Hospice Interdisciplinary Teams
Under CAA, 2023, a hospice program should have an interdisciplinary team that includes at least one social worker, MHC, or MFT. ACA understands that the roles and training of SWs, MFTs, and MHCs vary greatly and appreciates the unique support and services SWs provide to patients and their families. SWs can help patients and their families navigate the health care system and connect beneficiaries with critical social support services, among other benefits. ACA concurs with CMS that the needs, preferences, and goals of each hospice patient and family should be considered when determining which practitioner type (SW, MFT, or MHC) should serve on a hospice team. We note, however, that the grief and bereavement counseling that hospice patients and their families may need from a counselor with a master's or higher degree should be distinguished from the case management services provided by social workers on a hospice interdisciplinary team. These different types of supports may both be needed, and hospice programs should be encouraged to ensure access to both, to the extent possible.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
CAA, 2023, adds MFTs and MHCs as eligible practitioners of RHCs and FQHCs beginning January 1, 2024. ACA applauds CMS' proposal to allow MHCs and MFTs to provide services furnished at RHCs and FQHCs. While demand for mental health services has increased in recent years, there is a severe shortage of mental health providers, especially in rural communities. As noted in CMS' proposal, sixty-five percent of federally designated health professional shortage areas are in rural areas.[5] Allowing MHCs to furnish mental health services at RHCs and FQHCs will help alleviate the severe shortage of mental health professionals in rural communities, which has only exacerbated the mental health crisis among older adults.

Mobile Crisis Services
MHCs can play an essential role in providing mental health services to individuals experiencing mental health crises, with training in de-escalation, trauma-informed care, triaging situations that require psychological intervention, and providing longer-term therapeutic support. We appreciate Congress's expansion of access to mobile crisis services to Medicare beneficiaries in Section 4123 of CAA, 2023, based on the success of Eugene, Oregon's "CAHOOTS" (Crisis Assistance Helping Out On The Streets) program and similar model programs around the country. Mobile crisis teams can reduce the need for police to intervene in non-violent behavioral crises, avoid emergency department boarding and jail, more appropriately address behavioral health crises, and encourage individuals at risk to seek professional help.

We support CMS' proposal to create two new G-codes (GPFC1 and GPFC2) to describe psychotherapy for services furnished in places of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting. Given the new Medicare benefit category for MHCs and MFTs, ACA anticipates these licensed practitioners will be eligible for separate Medicare reimbursement for providing mobile crisis services as part of a team. We would appreciate CMS clarifying in the final rule and in guidance to Medicare

[5] https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.

Administrative Contractors that MHCs (and MFTs) may be reimbursed for services reflected in the new G-codes.

Merit-Based Incentive Payment System (MIPS)

CMS did not make any proposals regarding MHCs and the Quality Payment Program (QPP) in the proposed rule. We understand that new Medicare-enrolled eligible clinicians are not treated as MIPS eligible clinicians until the subsequent year (and performance year of the subsequent year),[6] such that MHCs and MFTs would not be subject to MIPS in CY 2024. However, our members request that CMS consider and address the participation of such practitioners under the QPP. We recognize that CMS has discretion to specify additional MIPS-eligible clinicians, such as MHCs and MFTs,[7] and has done so recently for practitioners like CSWs.[8] We believe such an assessment of whether MHCs and MFTs could successfully participate in MIPS, including consideration of whether measures are sufficient and activities are applicable for these types of practitioners, is needed. We would like the benefit of taking advantage of programs such as the QPP, as appropriate, and request that CMS provide additional guidance on that topic in the near future.

Conclusion

ACA appreciates the opportunity to provide CMS with comments concerning the PFS proposed rule for CY 2024. As MHCs transition into the Medicare program for the first time in history, ACA appreciates CMS's early outreach and ongoing communication with the association and CMS's work to prepare for MHCs and MFTs to enroll and most effectively serve Medicare beneficiaries. We hope we can continue to partner with you and serve as a valued resource as you seek ways to improve Medicare beneficiaries' access to behavioral health services. Please contact Brian Banks, Chief Governmental Affairs and Public Policy Officer for ACA, at 703-543-9471 or BBanks@Counseling.Org if you have any questions or need additional information.

Sincerely,

Shawn E. Boynes, CAE, FASAE
Chief Executive Officer
American Counseling Association

[6] Section 1848(q)(1)(C)(v) of the Social Security Act; 42 CFR §§ 414.1305 and 1310(c).
[7] Section 1848(q)(1)(C)(i)(II) of the Act.
[8] 86 Fed. Reg. 65687-65689 (Nov. 19, 2021).