

September 5, 2022

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The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
ATTN: CMS-1770-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: [CMS-1770-P] 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; et al.

Dear Administrator Brooks-LaSure:

The [American Counseling Association](http://www.counseling.org) (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 counselors in various practice settings, with most of its approximately 60,000 members practicing in the United States. We greatly appreciate the opportunity to comment on the Physician Fee Schedule (PFS) Proposed Rule for Calendar Year (CY) 2023 (CMS-1770-P)¹ and specifically on the Centers for Medicare & Medicaid Services' (CMS) proposal to increase flexibilities for Medicare-eligible mental health practitioners to use services provided by Licensed Professional Counselors² (LPCs) and Licensed Marriage and Family Therapists

¹ 87 Fed. Reg. 45860 (July 29, 2022).

² States may identify LPCs by other 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](#).

(LMFTs) to treat Medicare beneficiaries. We appreciate CMS’s recognition of the important role these highly trained professionals play throughout the nation’s mental health services delivery system, and particularly in rural and historically underserved communities.

LPCs provide mental health and substance abuse care to millions of Americans. More than 160,000 LPCs are currently licensed and trained to treat mental, behavioral, and emotional disorders across the country, under licensure laws enacted in all 50 states, the District of Columbia, and Puerto Rico. State licensure requirements for LPCs 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 etiology of mental illness and substance use disorders, effective treatment and counseling strategies, ethical practice, and other core knowledge areas;
- 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 Ethics³ and recognized standards of practice, as regulated by the state’s counselor licensure board; and
- Periodic completion of continuing education credits/hours after obtaining licensure to remain current in their field of practice.

LPCs practice in a variety of settings, including in community behavioral health clinics, substance use treatment centers, hospitals, K-12 schools and higher educational institutions, employee assistance programs, and for federal agencies and non-profit and faith-based organizations. The vast majority of LPCs, however, practice independently once they complete the supervised clinical experience required for licensure in their state.⁴ These practitioners, who have graduate degrees and clinical training specific to mental health counseling, are eligible to participate in virtually all managed care and health plans and receive reimbursement by third party insurance payers -- *except* Medicare. The Medicare statute only authorizes direct reimbursement for mental health services provided by psychiatrists, psychologists, psychiatric nurse specialists, and licensed clinical social workers, and excludes LPCs and LMFTs, even though LPCs’ and LMFTs’ level of education and training can be comparable to or exceed those of similar mental health professionals.⁵

The American Counseling Association has been working with Congress to close the Medicare mental health coverage gap so that LPCs and LMFTs can bill and receive direct

³ A number of states specifically require LPCs to abide by the American Counseling Association’s [Code of Ethics](#), as most recently revised and updated in 2014. Other states use an adapted version of the ACA’s Code of Ethics in their licensure rules.

⁴ The American Counseling Association, “[Counselors’ Interest in Working With Medicare Beneficiaries: A survey of licensed professional mental health counselors](#),” April 29, 2022 (ACA Survey), p. 4 (out of those responding, 61.54% reported having their own practice).

⁵ Congress has not updated the Medicare mental health provider list, in section 1861(s)(2) of the Social Security Act, since 1989. Fullen, M., Wiley, J., Morgan, A., “[The Medicare Mental Health Coverage Gap: How Licensed Professional Counselors Navigate Medicare-Ineligible Provider Status](#),” *The Professional Counselor*, Vol. 9, issue 4 (2019).

payment from the Medicare program regardless of practice setting. The ACA believes that, for older and disabled adults on Medicare, barriers to behavioral health care services lead to worse health outcomes, and increases the heavy toll taken on individuals, their families and the taxpayers by more costly interventions for both mental and medical health conditions. We are pleased that the Administration, in its FY 2023 budget, supports the modernization of Medicare’s mental health coverage and urges Congress to establish a benefit category for services provided by LPCs and LMFTs. Congressional passage of bipartisan legislation pending in Congress, H.R. 432/S. 828, the “Mental Health Access Improvement Act,” would accomplish this long-overdue reform, expand access to behavioral health services for older and disabled adults on Medicare, alleviate the national behavioral health workforce shortage, and reduce longer term costs for the Medicare program.⁶

We recognize that, without Congressional action, CMS’s ability to expand Medicare beneficiaries’ access to LPCs and LMFTs is limited, and support all steps CMS can take to increase beneficiary access to these practitioners within its regulatory authority. As CMS indicates, “general supervision” is a more flexible type of supervision that would not require the Medicare-eligible provider to be present in the clinic when an LPC or LMFT treats a Medicare beneficiary, although the Medicare-eligible provider must still submit the reimbursement claim. Auxiliary personnel providing “incident to” health care services must be employees, leased employees, or independent contractors of the participating provider or legal entity billing Medicare.⁷ We are hopeful that allowing general supervision, as opposed to direct supervision, may alleviate some of the mental health workforce challenges in settings that already have supervision in place, such as Federally Qualified Health Centers and Rural Health Clinics, and incentivize these important primary care providers to hire and contract with more LPCs and LMFTs.

Recommendation 1 - Include Associate Counselors completing their supervised clinical training requirements to be “auxiliary personnel”

As a result of the Medicare mental health coverage gap, as the counseling profession has grown over the past several decades, LPCs have had limited opportunities to treat older individuals. The majority of our members are interested in directly serving the Medicare population. In response to a survey we conducted in April 2022, over 72 percent of our members indicated that, if Congress amends the statute, they will become a Medicare-approved provider.⁸

In order to build a pipeline of LPCs and LMFTs with experience serving the Medicare population, we urge CMS to include state licensed Associate Counselors as “auxiliary personnel” in the “incident to” regulation. Associate Counselors are individuals who have met their state’s graduate education and exam requirements for being a professional counselor but have not yet met the supervised experience requirement, and hold an Associate License.⁹ Although LPCs

⁶ Morgan, A., Fullen, M., Wiley, J., *“A Case of the Tail Wagging the Dog: The Medicare Mental Health Coverage Gap and Its Impact on Providers and Beneficiaries,”* Journal of Mental Health Counseling 44(1):32-48 (January 2022).

⁷ See 42 CFR § 410.26(a)(1) (defining auxiliary personnel).

⁸ ACA Survey, p. 5.

⁹ States’ titles for these practitioners vary. Examples of such titles include Licensed Associate Counselor (LAC), Licensed Professional Counselor Associate (LPCA), Licensed Graduate Professional Counselor, counselor-in-training, and Clinical Resident.

typically supervise Associate Counselors' clinical training, allowing Associates to train with a Medicare-eligible provider (such as a psychologist) would create opportunities for Associates to gain experience treating older and disabled individuals on Medicare, while meeting more Medicare beneficiaries' behavioral health needs. Specifically, we suggest CMS amend the definition of "auxiliary personnel" in 42 C.F.R. 410.26(a)(1) to add at the end:

"except in the case of behavioral health services provided by auxiliary personnel who meet the State's licensure requirements to be Associate Counselors or the equivalent and are completing their clinical training requirements for purposes of licensure in the State in which the services are being furnished."

Recommendation 2 - Clarify Supplemental Payer Coverage Requirements

The ACA also urges CMS to clarify that LPCs may be reimbursed by the *Medicaid* program for services they provide to dually-eligible Medicare beneficiaries, without documentation of a Medicare claim denial or, alternatively, create a protocol to provide such a denial so that the Medicaid program will process the claim.¹⁰ As CMS is aware, people dually enrolled in Medicare and Medicaid are among the nation's most vulnerable populations, often coping with multiple chronic medical and behavioral health conditions, long-term care needs, and destabilizing and adverse social determinants of health such as lack of transportation and food and housing insecurity. In most states, Medicaid authorizes LPCs to provide counseling services and to submit claims directly for reimbursement, but where individuals are covered by both Medicare and Medicaid, Medicare is typically the primary payer. Since LPCs are not recognized as Medicare providers, LPCs cannot submit claim or receive a claim denial for purposes of "triggering" Medicaid coverage the beneficiary would otherwise have. The lack of clarity around eligible providers between the two programs can interfere with effective behavioral health treatment and exacerbate fragmented care, reducing the ability of individuals and health systems to manage complex conditions.

Similarly, the ACA urges CMS to clarify that a claim denial (or letter) from Medicare is not needed for purposes of LPCs seeking reimbursement for behavioral health services from Medigap plans or other plans that supplement Medicare benefits such as retiree and group health plans. Alternatively, we request that CMS establish a protocol to provide such a denial so that the supplemental plan can move forward with processing the claim. This would be a significant help to Medicare beneficiaries whose supplemental coverage would otherwise permit direct billing by LPCs, improve coordination of benefits, and ensure that beneficiaries have broader access to these practitioners.

Conclusion

The ACA appreciates the opportunity to provide CMS with comments concerning the proposed rulemaking for the Physician Fee Schedule for CY 2023 Payment Policies. 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 essential behavioral health services.

¹⁰ Among Medicare beneficiaries in traditional Medicare, as of 2018, most (83%) have supplemental coverage, either through Medigap (34%), employer-sponsored retiree health coverage (29%), or Medicaid (20%). and by the Medicaid program where a beneficiary is dually eligible. W. Koma, et al., "[A Snapshot of Sources of Coverage Among Medicare Beneficiaries in 2018](#)," Kaiser Family Foundation Medicare Issue Brief (March 23, 2021).

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 any additional information.

Sincerely,

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