Medicare Mental Health Workforce Coalition

September 12, 2025

The Honorable Mehmet Oz, MD
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-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 Administrator Oz:

The undersigned behavioral health and patient groups are members of the Medicare Mental Health Workforce Coalition ("Coalition"). We are comprised of national and state organizations collectively representing hundreds of thousands of mental health and addiction disorder providers, patients, families of patients, payers, and other stakeholders in the mental health provider system. The Coalition provides the feedback set forth in this letter regarding the proposed regulations to implement changes to the Medicare physician fee schedule ("PFS") and other Medicare Part B payment policies that impact licensed marriage and family therapists ("MFTs"), licensed mental health counselors ("MHCs"), and licensed clinical social workers ("CSWs").

MHCs, CSWs, and MFTs provide necessary behavioral health services to Medicare beneficiaries and make up the majority of providers providing these services. According to CMS provider enrollment data, as of June 30, 2025, there were 166,733 CSWs, MFTs, and MHCs who were enrolled as Medicare Part B providers.[1] Section 4121 of the Consolidated Appropriations Act ("CAA"), 2023, provided for coverage of MHCs and MFTs under Medicare Part B. Due to this

[1] Based upon a search of all Search of all CSWs, MFTs, MHCs by enrollment type: clinical social worker (14-80), marriage and family therapist (14-E1) and mental health counselor (14-E2). See Medicare Fee-For-Service Public Provider Enrollment Files. https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/medicare-fee-for-service-public-provider-enrollment

critically important change, 70,438 MHCs and MFTs are now enrolled as Medicare Part B providers as of June 30, 2025. This substantial increase in the number of Medicare-eligible behavioral health providers allows beneficiaries the ability to access a substantially larger pool of providers than they were able to access prior to January 1, 2024, the effective date of the implementation of the CAA, 2023 provision providing for coverage of MFTs and MHCs as Medicare providers.

COMMENTS ON THE 2026 PROPOSED RULE

The Coalition has reviewed the proposed rule as it pertains to the inclusion of MFTs, MHCs, and CSWs as Medicare providers. While the Coalition is pleased in general with the proposed rules, we are providing the following comments and recommendations for consideration.

Comments on Advancing Access to Behavioral Health Services

The Coalition strongly supports the efforts of CMS to advance access to behavioral health services through clarification of Community Health Integration ("CHI") and Principal Illness Navigation ("PIN") services for MFTs, MHCs and CSWs, the expansion of Digital Mental Health Therapy payment policies, and consideration of additional digital health innovations. These proposals recognize the essential role that CSWs, MHCs, and MFTs play in addressing social determinants of health, integrating behavioral health with medical care, and utilizing innovative technologies to improve patient outcomes.

<u>Community Health Integration and Principal Illness Navigation Services</u>

In the PFS, CMS has proposed that when CMS refers to "certified or trained auxiliary personnel" in the HCPCS codes G0019, G0022, G0023, G0024, G0140, G0146 pertaining to CHI and PIN services, this definition also includes MFTs and MHCs. CMS has also proposed that MHCs and MFTs can bill Medicare directly for CHI and PIN services that they personally perform for the diagnosis or treatment of mental illness. In addition, CMS is proposing to allow CSWs, MHCs, and MFTs to bill for CHI initiating visits. The Coalition strongly supports all of these proposals.

The Coalition strongly supports the proposal to include MHCs and MFTs as "certified or trained auxiliary personnel." In the CY 2025 PFS final rule, CMS clarified that when it refers to "certified or trained auxiliary personnel" in the HCPCS codes G0019, G0022, G0023, G0024, G0140, G0146, this definition also includes CSWs. Given their comprehensive training in psychosocial assessment and community resource coordination, MHCs and MFTs are also uniquely positioned to provide these services. MFTs and MHCs have extensive experience connecting individuals with community-based resources to address unmet social needs that affect both mental health and medical conditions. Their training in systems theory, community mental health principles, and case management

makes them particularly effective at identifying upstream drivers of health problems and coordinating comprehensive care plans.

The clarification that MHCs and MFTs 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. MFTs, CSWs, and 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. The flexibility allowing these providers to serve as auxiliary personnel under the supervision of other billing practitioners expands opportunities for integrated care delivery, particularly in settings where mental health practitioners work collaboratively with primary care providers, physicians, and other healthcare professionals to address complex patient needs involving both medical and behavioral health components.

The Coalition also strongly supports allowing CSWs, MHCs, and MFTs to bill for CHI initiating visits. This provision recognizes that mental health professionals are often the first point of contact for identifying patients who would benefit from community health integration services, particularly given their expertise in assessing social determinants of health that impact mental health outcomes. CSWs, MHCs, and MFTs routinely evaluate housing stability, food security, transportation barriers, social isolation, and other upstream factors that affect both mental health conditions and overall health outcomes. Their ability to initiate CHI services ensures that patients receive timely access to comprehensive care coordination when these social needs are identified during mental health treatment. This billing capability also supports integrated care models where mental health professionals work within primary care settings or collaborative care arrangements, enabling them to seamlessly connect patients with community resources while maintaining continuity of care and appropriate documentation for quality improvement and outcome measurement purposes.

Digital Mental Health Innovation and Payment Policies

The Coalition strongly supports CMS's proposal to expand payment policies for Digital Mental Health Therapy (“DMHT”) devices to include those cleared for Attention Deficit Hyperactivity Disorder (“ADHD”) treatment. CSWs, MHCs, and MFTs frequently treat patients with ADHD across the lifespan, and evidence-based digital interventions can significantly enhance traditional therapeutic approaches. The expansion of DMHT coverage to include ADHD-specific devices recognizes the growing evidence base supporting digital therapeutics for attention and executive functioning disorders. MFTs, CSWs, and MHCs are trained in ADHD assessment and treatment, and they 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.

Software as a Service Payment Policy

The Coalition supports consideration of payment policies for Software as a Service ("SaaS") applications in mental health treatment. SaaS platforms offer several advantages for mental health service delivery, including 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.

Advanced Primary Care Management and Behavioral Health

The Coalition supports the addition of Behavioral Health Integration ("BHI") and Psychiatric Collaborative Care Model ("CoCM") services intended for providers who provide Advanced Primary Care Management ("APCM") services. Clients living with chronic conditions often have co-occurring behavioral health diagnoses that can entirely change the trajectory of their health and treatment plans. Aligning these codes to fit into the existing care models of interdisciplinary health teams further supports current practices while expanding patient access to behavioral health within primary care settings.

The Coalition supports the continued use of the APCM G-codes and urges CMS to adopt complexity modifiers to better reflect the diverse needs of patients receiving Collaborative Care. Such modifiers would balance administrative simplicity with fair reimbursement for patients with higher clinical complexity. This approach aligns with CMS's stated goal to reduce reporting burden while enabling providers to sustain high-quality care. We recommend a two-tiered complexity structure, modeled on Chronic Care Management crosswalks and grounded in clinical indicators of behavioral health severity. This framework avoids the reintroduction of time-tracking requirements while providing a transparent method for recognizing higher clinical effort. Moderate complexity could reflect the presence of multiple comorbid behavioral health conditions, while high complexity might encompass patients with substance use disorders, suicide risk, or other serious behavioral health impairments. Importantly, this model would support continued delivery of high-fidelity Collaborative Care without limiting practices to an artificial one-hour cap per patient per month.

Social Determinants of Health Risk Assessment

CMS is proposing to delete the code for Social Determinants of Health Risk Assessment (HCPCS code G0136). While we understand the rationale for proposing to delete this code for Social Determinants of Health Risk Assessment, we encourage careful consideration of the impact on behavioral health services. MHCs, CSWs, and MFTs routinely assess social determinants as part of comprehensive mental health evaluations, as these factors significantly influence mental health outcomes and treatment planning. Social determinants assessment is particularly critical in mental

health treatment because factors such as housing instability, food insecurity, transportation barriers, and social isolation directly impact mental health symptoms and treatment adherence. If this code is deleted, we recommend that CMS ensure that existing codes adequately capture the time and complexity involved in comprehensive social determinants assessment as performed by CSWs, MHCs, and MFTs.

Prevention and Management of Chronic Disease – Request for Information

The Coalition supports the Administration's focus on understanding and lowering chronic disease rates, and efforts to ensure that CMS and other agencies provide expanded benefits to support helpful lifestyle changes and disease prevention and management. We appreciate this important request for information pertaining to the prevention and management of chronic disease.

In its request for information, CMS specifically asked about whether to create additional coding and payment for motivational interviewing. The Coalition strongly supports motivational interviewing as a covered service. Motivational interviewing is an evidence-based therapeutic approach widely used by MFTs, MHCs, and CSWs in a variety of settings. CSWs, MHCs, and MFTs are trained to use motivational interviewing techniques. Motivational interviewing aligns with core principles of client-centered care, strength-based intervention, and collaborative treatment planning. 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.

The Coalition strongly supports CMS's consideration of creating additional coding and payment for motivational interviewing. 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.

In terms of clinical staff who should be able to perform motivational interviewing under the general supervision of a billing practitioner, we believe that any licensed behavioral health professional should be able to perform these services under the supervision of a CSW, MHC, MFT, or other billing practitioners. We also believe that associate MHCs, MFTs, and CSWs who have met the applicable educational requirements under Medicare law to enroll as a billable MHC, MFT, or CSW and who are currently working to obtain their supervised clinical experience to become licensed as an MHC, MFT, or CSW should also be eligible to provide motivational interviewing services under the general supervision of a MHC, MFT, or CSW.

Like other healthcare services, motivational interviewing is a service that can be performed via audiovisual or audio-only synchronous telecommunication, and CMS should allow this service to be provided via audiovisual or audio-only synchronous telecommunication.

Medicare Telehealth Services

The Medicare Mental Health Workforce Coalition supports CMS's proposed telehealth policy changes, which represent significant improvements for mental health service delivery to Medicare beneficiaries. These proposals will enhance access, improve clinical outcomes, and support innovative service delivery models. We particularly support the streamlined Medicare Telehealth Services List process, the addition of Multiple-Family Group Psychotherapy (90849), and the permanent adoption of audio/video direct supervision.

Removing Provisional/Permanent Distinctions

In the PFS, CMS is proposing to simplify its telehealth list review process by focusing on whether the service can be furnished using an interactive telecommunications system, as well as to remove the distinction between "permanent" and "provisional" services. The Coalition strongly supports eliminating the provisional/permanent categorization and simplifying the review process to focus on whether services can be safely furnished via interactive telecommunications systems. Telehealth is a modality for providing the same care, but through telehealth means. There is no need for a requirement to reexamine a service that CMS has already deemed to have clinical value.

Multiple-Family Group Psychotherapy and Group Behavioral Counseling for Obesity

CMS is proposing to add telehealth payment for Behavioral Counseling for Obesity and Multiple-Family Group Psychotherapy. The Coalition strongly supports the addition of these codes for Multiple-Family Group Psychotherapy (90849) and Behavioral Counseling for Obesity (G0473).

Multiple-family group psychotherapy represents an evidence-based intervention that is particularly well-suited for telehealth delivery. Telehealth delivery of Multiple-Family Group Psychotherapy can facilitate participation from family members who might otherwise be unable to attend in-person sessions due to work schedules, caregiving responsibilities, or geographic distance. Multiple-family groups allow families to learn from each other's experiences and develop mutual support networks, which can be effectively facilitated through telehealth platforms. Telehealth delivery of multiple-family group psychotherapy will particularly benefit rural families and families with multiple scheduling constraints that make it difficult for these families to travel to a provider's office or clinic for in-person therapy.

The Coalition also supports adding Group Behavioral Counseling for Obesity to the telehealth list. Group behavioral health counseling for obesity benefits from telehealth delivery through reduced stigma, enhanced privacy to encourage more open discussion of eating behaviors and body image concerns, and greater family involvement.

Direct Supervision via Audio/Video Technology

The Coalition supports the permanent adoption of direct supervision via audio/video technology. The permanent adoption of audio/video direct supervision will significantly benefit mental health service delivery. This service will address the critical need for mental health supervision in rural and underserved areas with limited mental health professional availability by connecting supervised providers with expert supervisors regardless of geographic location, supporting the development of mental health services in underserved areas, and enabling experienced CSWs, MHCs, and MFTs to provide supervision across broader geographic regions. Audio/video supervision maintains appropriate clinical oversight while providing the needed flexibility in service delivery.

Telehealth Originating Site Facility Fee Update

The Coalition 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.

These telehealth proposals represent significant improvements that will enhance mental health service delivery for Medicare beneficiaries. The streamlined Medicare Telehealth Services List process, addition of telehealth payment for Multiple-Family Group Psychotherapy and Group Behavioral Health Counseling for Obesity, permanent audio/video direct supervision, and appropriate facility fee updates all support improved access, clinical effectiveness, and innovation in mental health care delivery.

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. The COVID-19 pandemic demonstrated that telehealth mental health services are not just an emergency measure, but a valuable permanent addition to the healthcare delivery system that improves access, reduces barriers, and supports better outcomes for Medicare beneficiaries with mental health needs. MHCs, MFTs, and CSWs stand ready to continue providing high-quality telehealth services to Medicare beneficiaries and appreciate support from CMS for these important service delivery innovations.

Rural Health Clinics and Federally Qualified Health Centers

CMS is proposing that services designated as care management services and added to the list of designated care management services could also be furnished in Rural Health Clinics (“RHCs”) and Federally Qualified Health Centers (“FQHCs”) and paid separately. The Coalition supports this proposal.

CMS is proposing to require, starting on October 1, 2025, that RHCs and FQHCS must ensure that there will be an in-person mental health service furnished within 6 months prior to the furnishing of the telecommunications service and that an in-person mental health service must be provided at least every 12 months while the Medicare beneficiary is receiving services delivered through telecommunications technology, unless the provider and patient agree that the risks and burdens outweigh the benefits associated with delivering the services in-person. The Coalition opposes this unnecessary requirement.

OMISSIONS FROM THE 2026 PROPOSED RULE

Telehealth Mental Health In-Person Visit Requirements and Access to Care Concerns

Beginning October 1, 2025, in-person visit requirements will apply for mental health services provided by telehealth. As a result, Medicare beneficiaries' access to care will be severely limited because they can no longer establish telehealth-only relationships with highly qualified providers. Our Coalition members are greatly concerned about the strain this lack of flexibility will have on an already inundated Medicare mental health system and the impact it will have on Medicare beneficiaries who cannot access care in-person due to reasons including, but not limited to, the following:

- Mental health symptoms
- Geographic barriers
- Transportation challenges
- Caregiver limitations

Although we recognize Medicare telehealth regulations are based upon Congressional action, the Coalition is compelled to take this opportunity to raise our concerns for Medicare beneficiaries whose safety and well-being will be jeopardized by telehealth access restrictions.

Distant Site Requirements

The proposed rule does not address allowing providers to use their currently enrolled practice location instead of their home address when providing telehealth services from their homes. Without action from CMS, this policy will end December 31, 2025.

It is important to protect the health and safety of healthcare practitioners, including mental health providers. Reports of violence against healthcare workers are prevalent, and violence against mental health professionals is even higher than in the healthcare profession at large. Home office

locations are less likely to have in place security staff and systems that may be more prevalent in commercial settings. Requiring that providers bill from their home location and enroll their home location in Medicare provides unnecessary risk of harm to the clinician, as their home address would become publicly available information.

In the CY 2025 PFS, Medicare continued to allow providers to use their practice location rather than home address through December 31, 2025. We strongly urge CMS to continue this policy through the end of 2026. We ask CMS to work to further address this issue with a more permanent fix, but are in support of keeping the current practice in place for the next year.

Reimbursement Rates

Under the current PFS, CSWs, MHCs, and MFTs are reimbursed at only 75% of the PFS rate received by physicians and psychologists. This rate is even lower than the 85% of the PFS rate that providers from several other Medicare-eligible professions receive. Although the number of behavioral health providers enrolled as Medicare Part B providers has increased since the addition of MHCs and MFTs as Medicare providers, effective January 2024, Medicare's low reimbursement rate for behavioral health services, in comparison to reimbursement offered through other parties, is hindering the recruitment of CSWs, MHCs, and MFTs as Medicare Part B providers. Increasing the reimbursement rate of these providers to 85% of the PFS would increase the recruitment and retention of CSWs, MFTs, and MHCs as Medicare providers. The Coalition urges CMS to look at policy changes to increase reimbursement rates.

Conclusion

The proposals by CMS to advance access to behavioral health services through expanded CHI and PIN services, digital health innovations, and recognition of evidence-based interventions like motivational interviewing represent significant opportunities to improve mental health care for Medicare beneficiaries. CSWs, MFTs, and MHCs are well-positioned to contribute to these 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, CSWs, and MFTs in integrated care delivery, digital health innovation, and evidence-based intervention implementation. These policies will support the 166,000 MFTs, MHCs, and CSWs who are enrolled as Medicare Part B providers and who are providing comprehensive, innovative, and effective mental health services.

The integration of behavioral health services with medical care, utilization of digital health and telehealth technologies, and recognition of specialized therapeutic approaches reflects the evolution of mental health treatment toward more comprehensive, accessible, and effective

service delivery models. CSWs, MHCs, and MFTs are ready to contribute to these advances and appreciate CMS's recognition of their essential role in comprehensive behavioral health care.

Thank you for all of CMS's efforts to bring about these important legal changes to expand access to behavioral health services by allowing Medicare payment for CSW, MFT, and MHC services. We are thrilled to be working in this field during this exciting time. If we can provide any additional information to you for consideration of these additional changes, please contact the Coalition representatives for this letter: Roger Smith, Chief Advocacy Officer at the American Association for Marriage and Family Therapy, rsmith@aamft.org or Brian D. Banks, Executive Director, Policy Advocacy and Research in Counseling Center & Chief Government Affairs Officer at the National Board for Certified Counselors, banks@nbcc.org.

Sincerely,

American Association for Marriage and Family Therapy
American Counseling Association
American Mental Health Counselors Association
California Association of Marriage and Family Therapists
National Association of Social Workers
National Board for Certified Counselors