HMA

WEBINAR SERIES

New Tools for Medicare Policy Changes Impacting Behavioral Health Services

OUR HMA EXPERTS: MEDICARE

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Marc is a board-certified psychiatrist and former CMO for a CMHC in Seattle. He has led system-wide transformation strategies that improve coordination to deliver person-centered care.

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Amy served over 15 years at CMS, including deputy director of CMMI and director of the hospital and ambulatory policy group. She also served at the Office of Management and Budget.

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Zach is an expert on complex Medicare payment policy, previously serving as MedPAC policy analyst, an expert advisor to a Congressional committee, & a GAO Medicare policy analyst.

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Jennifer is a licensed marriage and family therapist with expertise designing, innovating, and delivering integrated, multicultural behavioral health programs in primary, secondary, and tertiary settings.

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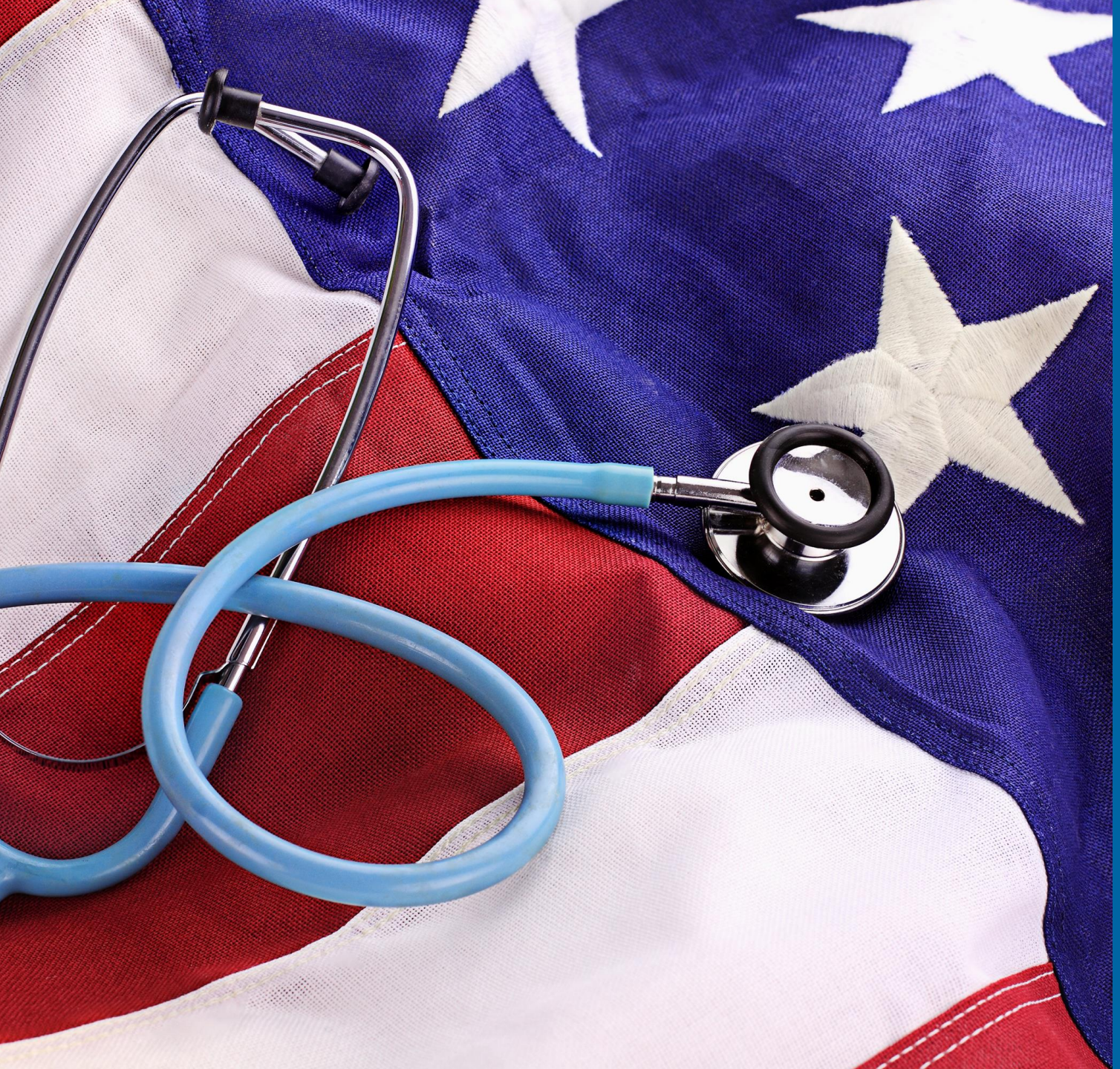
TODAY'S AGENDA & LEARNING OBJECTIVES

- Understand the recent Medicare regulatory and statutory changes to the Physician Fee Schedule (PFS) and Outpatient Prospective Payment Schedule (OPPS) impacting behavioral health providers, services, and reimbursement.
- Plan for the impact of regulation changes on demand for opioid/SUD treatment and telehealth/digital service delivery.
- Anticipate changes in demand for behavioral health services and the impact on your local market.
- Q&A



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NEW MEDICARE RULES FOR BEHAVIORAL HEALTH

MEDICARE AND MENTAL HEALTH COVERAGE

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Medicare beneficiary access to mental health services has been limited and mental health providers participated in Medicare at significantly lower levels than medical providers

- At its inception, Medicare had a limited mental health benefit. Over time, the benefit has grown through changes in statutory authority to add additional benefits, address cost-sharing and expand the types of practitioners that can provide outpatient services.

In 2022, CMS developed a Behavioral Health Strategy to better address these issues in Medicare and Medicaid

1. Strengthen Equity and Quality in Behavioral Health Care
2. Improve access to substance use disorders prevention, treatment and recovery services
3. Ensure effective pain treatment and management
4. Improve access and quality of mental health care and services
5. Utilize data for effective actions and impact on behavioral health

2023 MEDICARE BEHAVIORAL HEALTH STRATEGY

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As part of the Behavioral Health Strategy, CMS made multiple regulatory changes to Medicare provider requirements for 2023.

CMS allowed services provided by licensed professional counselors (LPC) and licensed marriage and family therapists (LMFT) under general supervision instead of direct supervision of a physician or non-physician practitioner

Any service furnished primarily for the diagnosis and treatment of a mental health or substance use disorder can be furnished by auxiliary personnel under the general supervision of a physician or NPP who can bill "incident to"

CMS created a new General BHI code describing a service personally performed by CPs or clinical social workers (CSWs) to account for monthly care integration where the mental health services are the focal point of care integration.

- Psychiatric diagnostic evaluation can serve as the initiating visit for the new general BHI service.

2024 PROPOSED MEDICARE PFS: BH REGULATORY CHANGES

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Who can bill

- Part B coverage for marriage and family therapists (MFTs) and mental health counselors (MHCs)*
- Addiction counselors that meet the requirements to be an MHC can enroll and bill *
- Add MFTs and MHCs to the list of practitioners who can furnish Medicare telehealth services at the distant site.*
- Add MFTs and MHCs to hospice interdisciplinary care team
- Updates coding requirements to allow LMFTs and MHCs to bill for Behavioral Health Integration and similar changes to Health Behavior Assessment and Intervention Services

Seeking comment on how to further expand access including use of digital therapies

What can be billed

- Payment amount for clinical social worker (CSW), MFT, and MHC services is 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for clinical psychologist services under the PFS*
- Increases valuation for timed behavioral health services.
- Create codes for psychotherapy for crisis services and establish enhanced payment in certain practice locations

*The Consolidated Appropriations Act, 2023 further expanded the Medicare behavioral health benefit; the PFS is implementing these provisions.

Comments to rule are due September 11, 2023

2024 PROPOSED MEDICARE PFS: OTHER TOPICS OF NOTE

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Updates to **payments** to physicians and practitioners who can bill under PFS scheduled to decrease by 3.34%

Proposal to implement a **new evaluation and management add-on code*** that physicians could use when they provide care to complex patients.

Updates to **telehealth** services

Proposal for a new **payment for caregiver training** - practitioners train and involve caregivers to support patients with certain diseases or illnesses (e.g., dementia) in carrying out a treatment plan.

Updating certain **provider enrollment** requirements

*The new code was finalized in the CY 2021 PFS rule, but Congress prohibited its implementation before CY2024.

Comments to rule are due September 11, 2023

2024 PROPOSED MEDICARE OPPS: REGULATORY CHANGES

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Proposed to create the Intensive Outpatient Program for behavioral health services for Medicare beneficiaries

- Distinct outpatient program of psychiatric services provided to individuals with acute mental illness or substance use disorder.
- Services could be provided at hospital outpatient departments, community mental health centers (CMHC), FQHCs, and RHCs.
- Two IOP payment amounts —one for days with three services per day and another with four or more services per day.
- Physician determine that each patient needs a minimum of nine hours of IOP services per week, and this determination must occur no less frequently than every other month.

Updates Partial Hospitalization Program rates

Refines existing coding for remote mental health services to allow for multiple units to be billed daily and creates a new, untimed code to describe group psychotherapy.

Updates the qualifications of MHCs and add personnel qualifications for MFTs in the CMHC Conditions of Participation (CoP).

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MEDICARE COVERAGE:

SUBSTANCE USE DISORDER TREATMENT AND VIRTUAL CARE

SUD: OUD COVERAGE INCLUDES COUNSELING AND MEDICATION WITHOUT END DATES AND BUNDLED PAYMENT

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In January 2020, Medicare began covering Opioid Use Disorder (OUD) Treatment

Parameters of Medicare OUD coverage

- Coverage: Counseling (individual and group), medication-assisted treatment (MAT), testing, and related items and services. Coverage not time or frequency limited (Cost-sharing = 20 percent)
- Patients choose treatment from either Opioid Treatment Programs (e.g., methadone clinics) or physician office
- Payment: Bundled, either weekly or monthly depending type of provider.
- Counseling may occur in-person or via telehealth
- Types of clinicians: Physicians, LCSWs, LPCs, licensed clinical alcohol and drug counselors, certified peer specialists who are permitted by state law and scope of practice to furnish these services

Other Medicare coverage for substance use disorder (SUD)

- Alcohol misuse screening (once per year) and counseling (4 times per year)
- Tobacco cessation counseling (8 times per year)

Medicare Advantage

- Plans' coverage must mirror or exceed coverage of Traditional Medicare
- Plans may negotiate their own payment rates with providers, and cost sharing varies by plan
- Plans may use prior authorization or network limits (85% of enrollees in plans that require prior auth for OTD)

MODIFICATIONS TO THE FOUNDATION OF SUD COVERAGE IN RECENT YEARS HAVE ADDED FLEXIBILITY TO CARE DELIVERY

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2019

OUD-Telehealth

- Preceding the OUD benefit, Congress lifts prohibition on telehealth services in urban areas and from patients' home for SUD services (coverage now permanent)

2020

Drug Enforcement Agency temporarily permits the prescribing of controlled substances via telehealth

- Initial policy flexibility during PHE (2020 to 2023)

2022

Mid-PHE policy changes

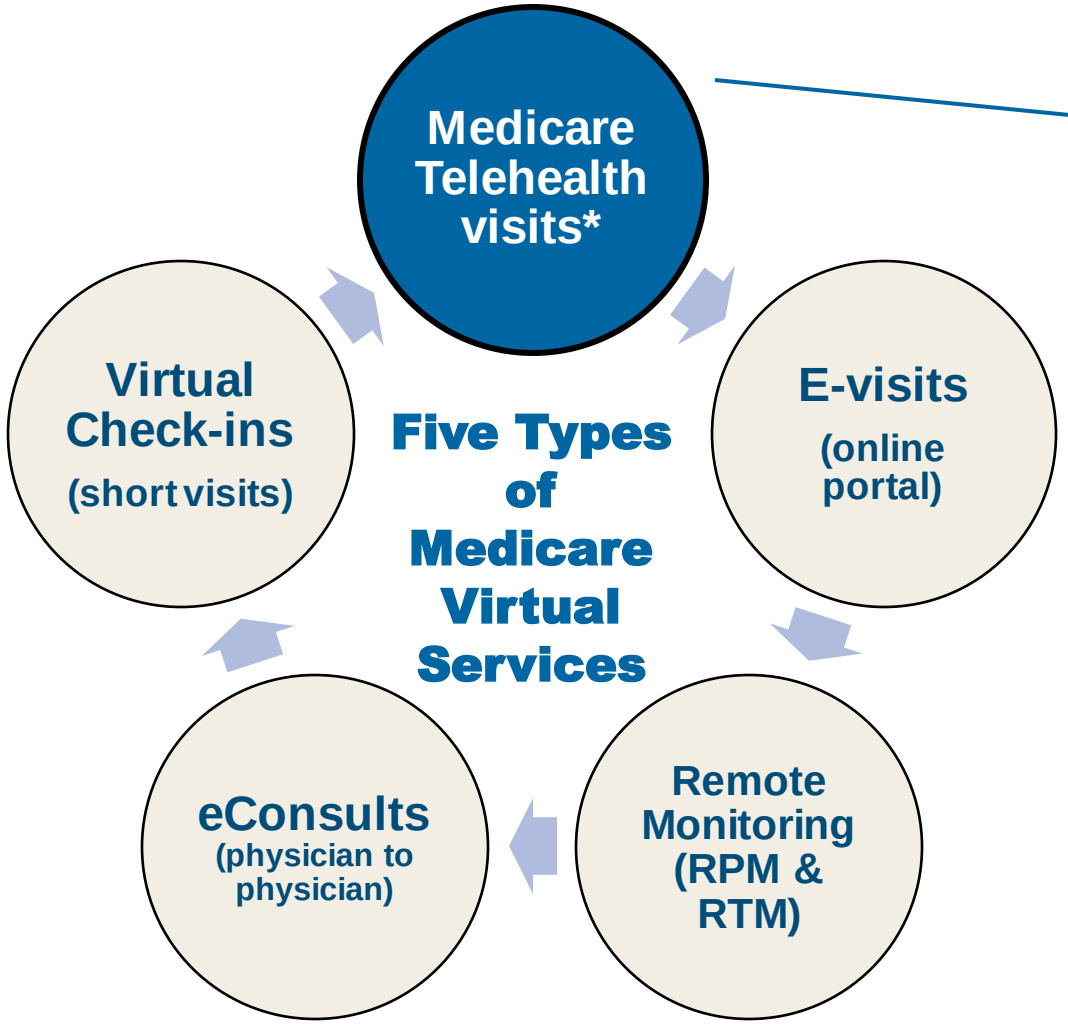
- CMS permanently covers audio-only telehealth for SUD
- Congress requires periodic in-person visits every 6-mos for tele-mental health services (not SUD).

2023

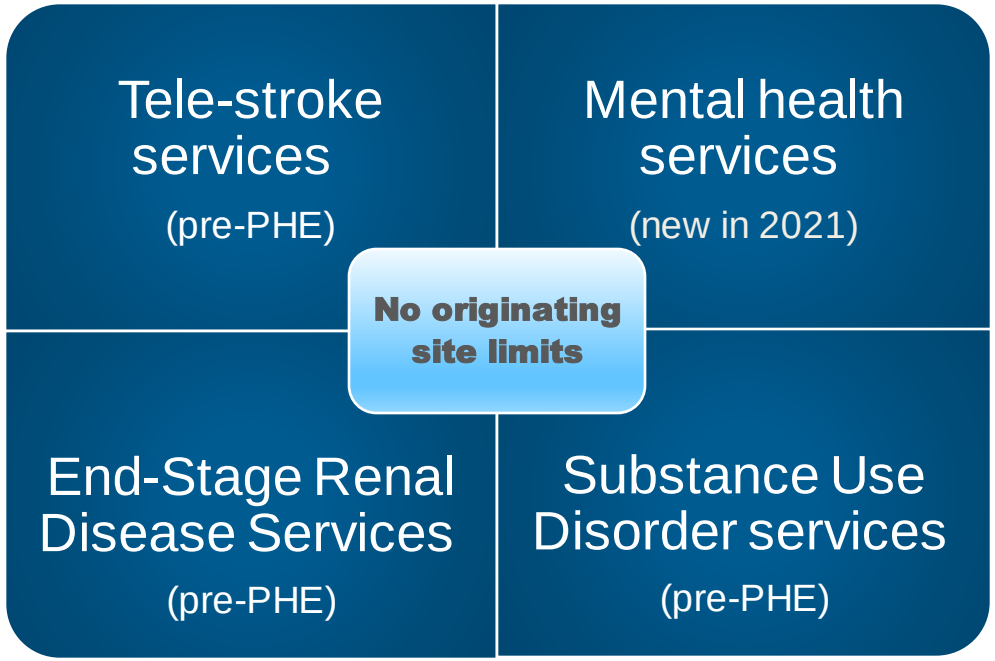
Post-PHE policy changes

- *Scope of practic*e: CMS permits licensed professional counselors, licensed marriage and family therapists, and other practitioners to provide SUD services under the general supervision of the billing physician or non-physician practitioner, not direct supervision
- *Tele-prescribing:* End of PHE, DEA extends tele-prescribing of controlled substances effectively through November 2024.

VIRTUAL CARE SERVICES: FIVE FORMS OF VIRTUAL CARE, TELEHEALTH SERVICES HAVE CRITICAL STATUTORY ORIGINATING SITE LIMITATIONS WITH A FEW EXCEPTIONS



Four services exempted from statutory geographic originating site limitations



*Subject to statutory geographic originating site limitations

DUE TO THE PHE, MEDICARE BECAME THE LEADING PAYER IN THE COVERAGE OF VIRTUAL CARE

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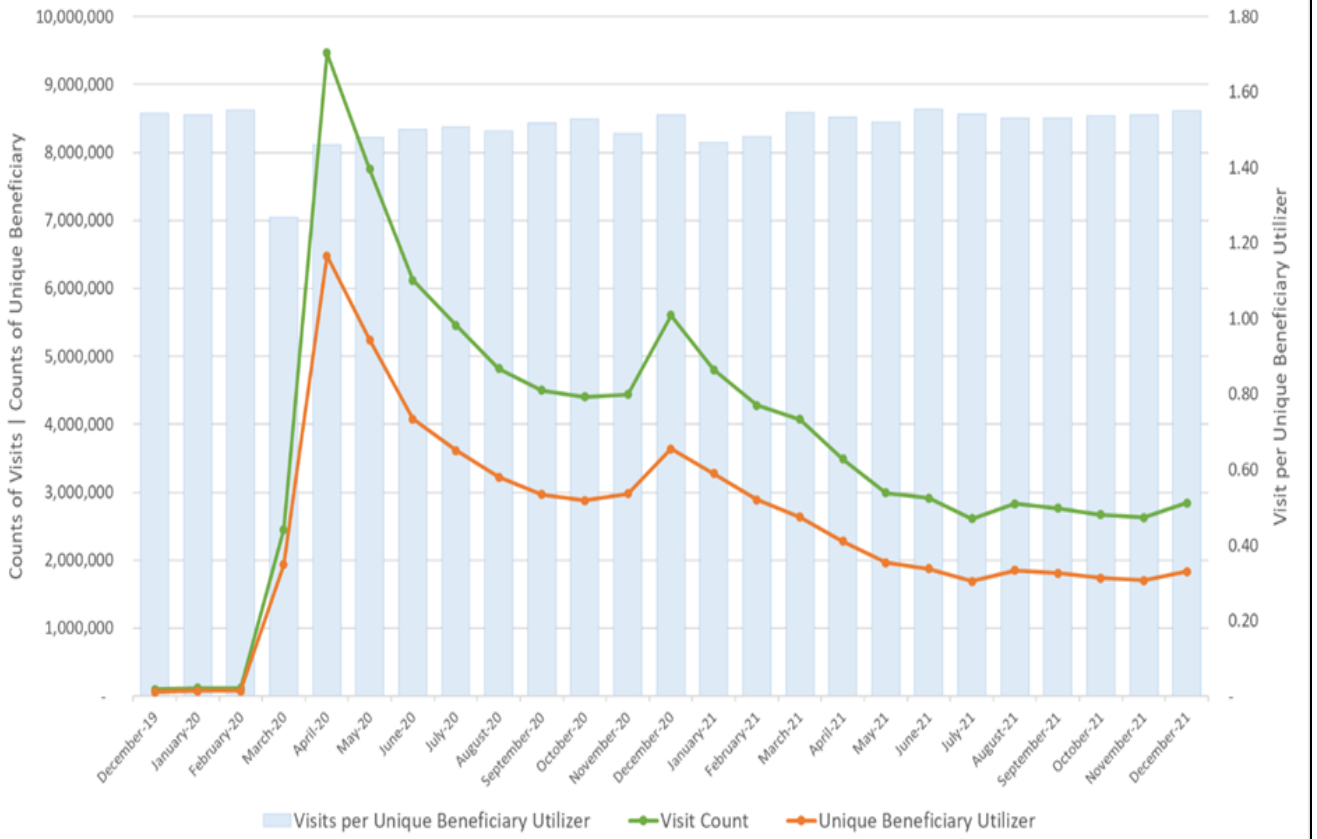
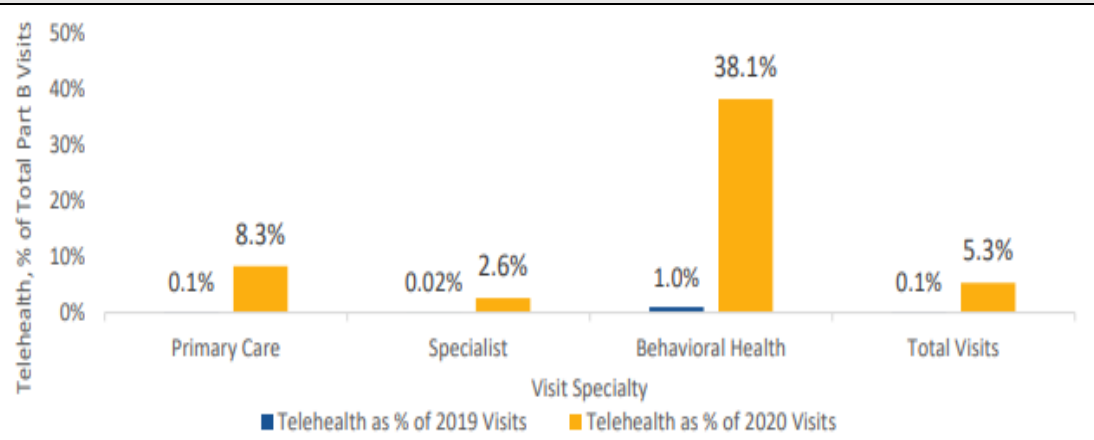
	Pre-PHE (permanent)	During PHE (temporary)
Originating sites:	Rural only, facility-based	Anywhere
Distant sites:	Clinicians in certain types of healthcare facilities	Clinicians' homes, FQHCs, RHCs, hospitals
Patients:	Established only	New and established
Cost sharing:	20%	Providers can waive
HIPAA:	Several requirements	Penalties waived
Telehealth crossing state lines:	Not permitted in most states	Permitted in most states
Telehealth visits:	• 100 service codes total (mostly E&M and behavioral health) • Two-way audio/video only	• More than 200 service codes added (e.g., ED, PT/OT therapy, speech, home visits) • Audio-only • Hospice home visits and recertifications • Home Health visits • Removal of frequency limits on inpatient and nursing follow-up care
CTBS:	RPM (2018), Virtual Check-ins (2019), E-consults (2019), E-visits (2020)	Expanded to new patients

IMPACT OF VIRTUAL CARE FLEXIBILITIES IN MEDICARE: SUDDEN AND SUSTAINED INCREASE IN USE, TELEHEALTH USE COMMON BEHAVIORAL HEALTH, RPM USE GROWING RAPIDLY

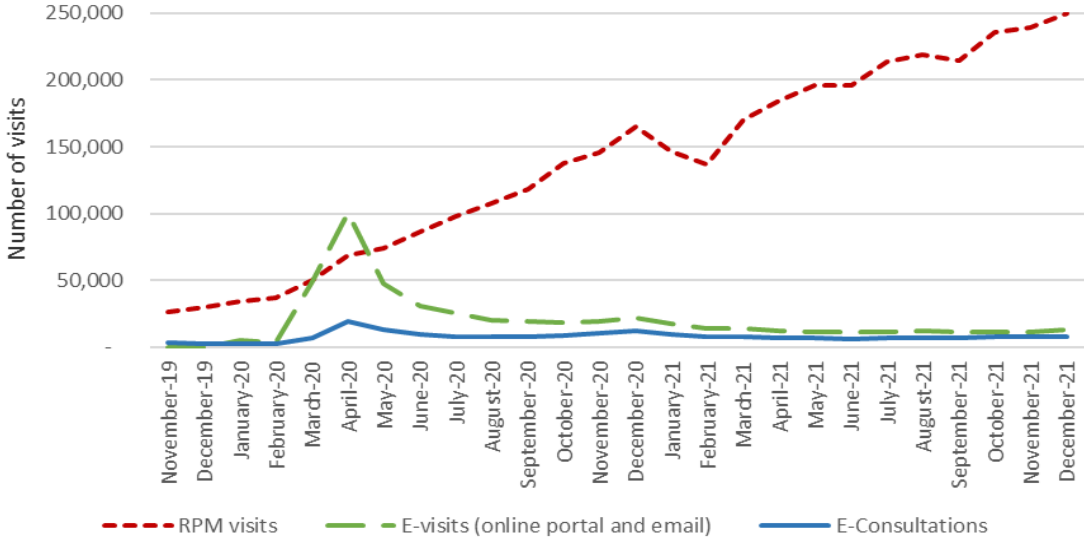
All beneficiaries – Any virtual care claim



Share of visits conducted via telehealth (behavioral health highest)



Medicare FFS use of RPM, E-visits, and E-consultations



Sources: HMA analysis of 100% Medicare claims data, 2019-2021 and HHS-ASPE analysis of Medicare claims

MEDICARE COVERAGE OF VIRTUAL CARE TODAY (2023) INCLUDES SEVERAL SIGNIFICANT TEMPORARY POLICIES

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Based on the impact of the PHE flexibilities, Congress and CMS made several policy changes in recent years, some permanent and others temporary.

The foundation of Medicare virtual care coverage remains in place

Permanent policies added between 2020-2023:

- Behavioral health services permitted with originating site limitation
- Audio-only permitted for behavioral health
- Expanded set of services may be conducted via telehealth: physical therapy, home health, emergency department, other
- Remote therapeutic monitoring services added
- New codes permitting different type of clinicians to conduct CTBSs

Temporary policies: Consolidated Appropriations Act of 2023 (Coverage ends December 31, 2024)

- Telehealth services may be provided from anywhere (urban, rural, home, other)
- Telehealth services may be conducted by FQHCs, RHCs, and many types of clinicians
- Audio-only visits for all types of clinical services
- Beneficiaries may receive tele-behavioral health services absent the requirement for a preceding in-person visit

SEVERAL SUD OR VIRTUAL CARE POLICY ISSUES MUST BE ADDRESSED BY POLICYMAKERS IN THE NEXT FEW YEARS

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SUD:

- The Drug Enforcement Agency will need to act before Nov 2024 to decide if the prescribing of controlled substances via telehealth is permitted or how it should be regulated

Virtual Care:

- Congress must act by the end of 2024 to avoid the disruption in the Medicare virtual care coverage

HIPAA:

- The Office for Civil Rights (OCR) must decide if it will return to the practice of imposing HIPAA penalties on providers who use public-facing remote communication technologies

Crossing state lines:

- State-level medical licensure boards must decide if they will permit patients to receive virtual care services from across state lines

Policies to adjudicate:

- The statutory limit on originating sites for telehealth services
- The inability of FQHCs and RHCs to service as distant sites
- Audio-only telehealth visits for services other than behavioral health
- The periodic in-person requirement for tele-behavioral health services
- Whether patients without an existing relationship with a clinician may receive CTBS like e-visits and remote monitoring

Key questions policymakers are considering:

- To what extent is fraud associated with telehealth services and does fraud vary by service/disease type?
- In what populations or disease groups might virtual care services most expand access to care?
- To what extent does virtual care increase spending or lead to the use of additional services?

HOW WILL THE POLICY ISSUES SETTLE?

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SUD:	• The opioid crisis continues, demand for care remains great • Tele-prescribing of controlled substances has become a part of the care infrastructure
Virtual Care:	• Congressionally mandated study due in 2026 could lead to more temporary policymaking • Virtual care has become a part of the care infrastructure • Behavioral Health is a key focus • Access and health equity remain a significant concern
HIPAA:	• Virtual care technology has improved in recent years, dampening some need for HIPAA as it relates to smartphones
Crossing state lines:	• Some state medical boards refuse to accept external providers

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MEDICARE BH POLICY CHANGES: IMPLICATIONS FOR CLINICAL PRACTICE(S)

HEALTH PROVIDER SHORTAGE AREAS (HPSAs)

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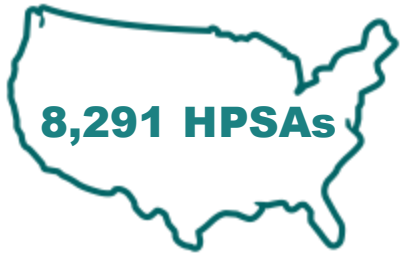
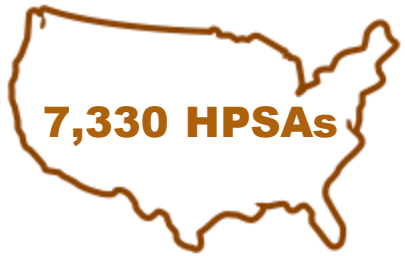
Primary Care



100M affected

17,266 clinicians needed

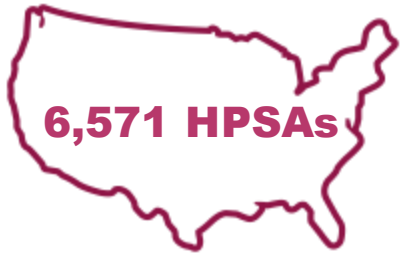
Dental Health



72M affected

12,238 clinicians needed

Mental Health



163M affected

8,252 clinicians needed

Data. HRSA.gov

[1] https://data.hrsa.gov/topics/health-workforce/shortage-areas

HRSA WORKFORCE PROJECTIONS

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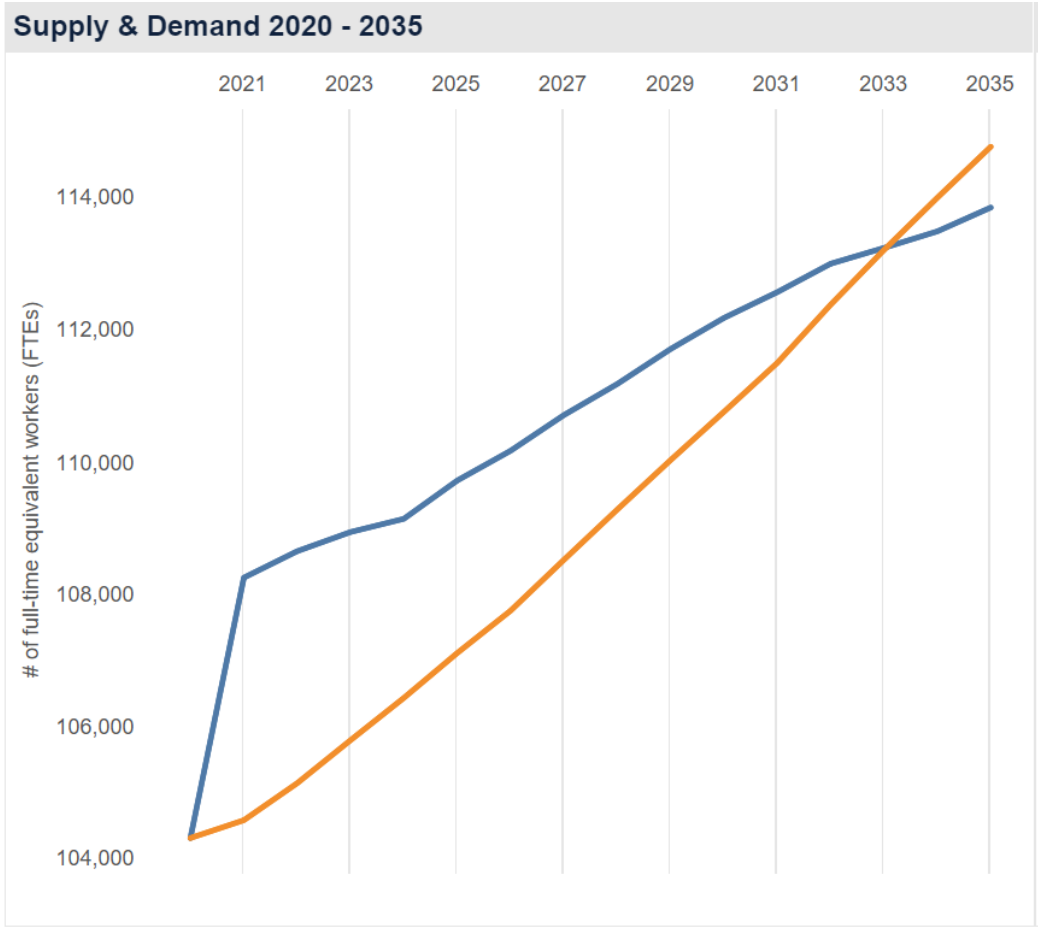

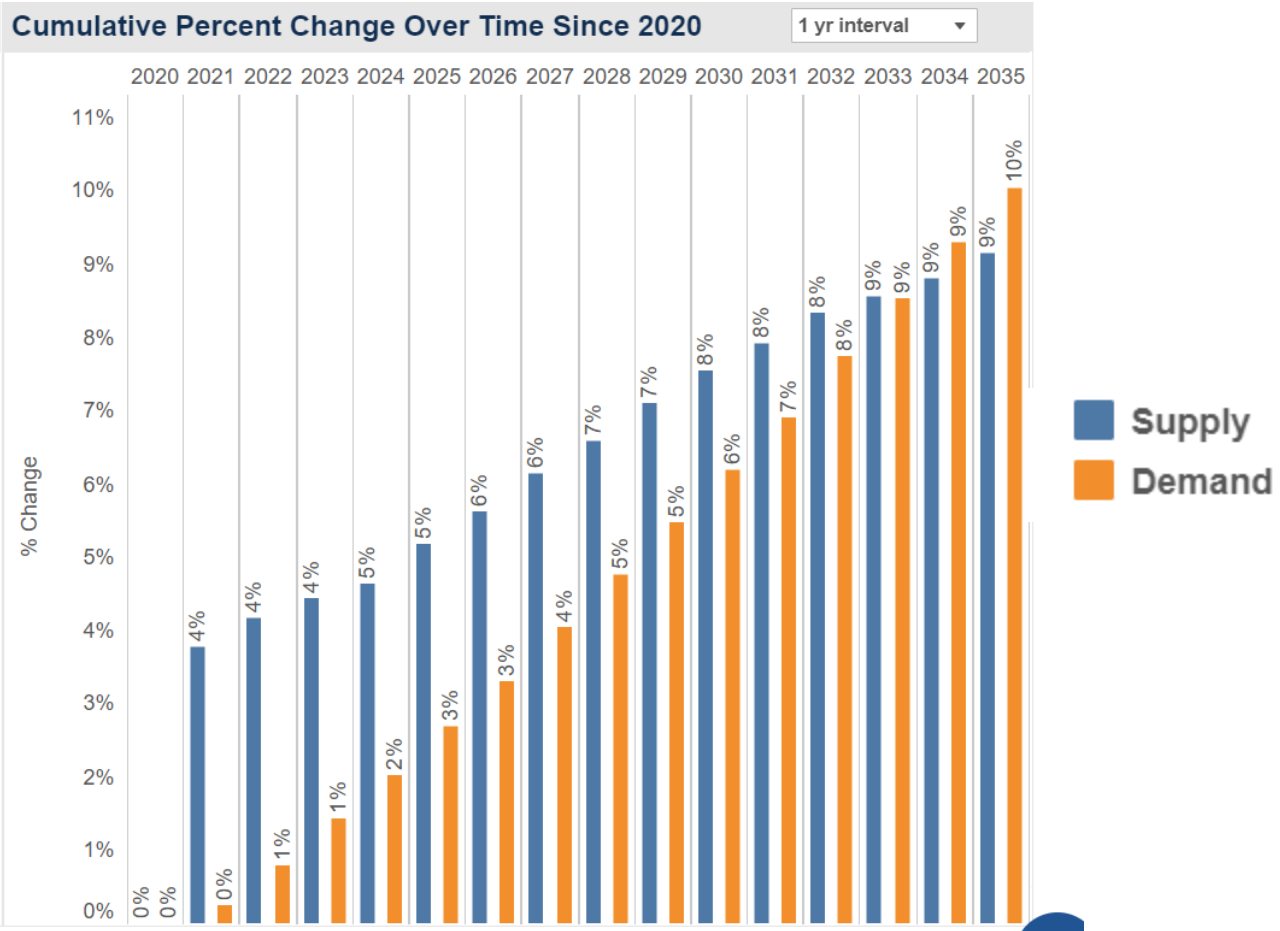

Date created: July 14, 2023

Click to navigate to alternate table view

Source: Department of Health and Human Services, Health Resources and Services Administration, Health Workforce Projections. Available at https://bhw.hrsa.gov/data-research/review-health-workforce-research

EXPANDING CLINICIANS THAT CAN BILL MEDICARE

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Change

As of January 1, 2024, the following are eligible to enroll in Medicare*:

- Marriage and Family Therapists (MFT)
- Mental Health Counselors (MHC)
- Addiction Counselors (can enroll as Mental Health Counselors)

*As long as meet applicable requirements

Implications for Clinical Practice

- ✓ **MFTs and MHCs will be eligible to furnish Medicare services, expanding workforce and decreasing shortage**
- ✓ **MFTs and MHC will be eligible as RHC and FQHC practitioners billable with same codes as Clinical Psychologists (CPs) and Clinical Social Workers (CSWs)**
- ✓ **MFTs and MHCs will not be eligible to provide inpatient services**

CHANGING CLINICIAN DUTIES AND WORKFLOWS

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Change

- **Existing** G0511 code for General Care Management code for use by RHCs or FQHCs when at least 20 minutes of qualified CCM or general BHI services are furnished to a patient in a calendar month; however, inherently for non-face-to-face services that may not be accounted for in the per visit payment for an in-person encounter.

- **New** HCPCS code (G0323) can be used to provide at least minutes per calendar month for care management services for behavioral health conditions (aka monthly care integration service) by a Clinical Psychologist (CP), Clinical Social Worker (CSW), MFT, and MHC

Implications for Clinical Practice

✓ **Increased independence of licensed psychologists, social workers, and other BH clinicians in integrated settings**

CHANGING CLINICAL WORKFLOWS AND DUTIES (2)

HMA

Change	Implications for Clinical Practice
• MFTs and MHCs (incl CP and CSW) may order diagnostic tests for the diagnosis and treatment of mental illness (as legal under state law). • CSWs, MFTs, and MHCs, in addition to CPs, allowed to bill under Health Behavior Assessment and Intervention (HBAI) services to assess, diagnose, and treat psychological and/or psychosocial behaviors association with a physical condition; playing a key role in a multidisciplinary approach to care delivered within hospitals and medical practices • To be reimbursed, services must be reasonable and necessary for the diagnosis and treatment of illness or injury or to improve functioning of a malformed body member.	✓ **More sustainable support for behavioral health providers to work in real time as a member of a multidisciplinary team** ✓ **Advancements in whole health care consistent with evidence-based research** ✓ **Allow for more patients to receive services that address psychological, behavioral, emotional, cognitive, and interpersonal care in the treatment/management of physical health problems**

Use CPT codes 96156, 96158, 96159, 96164, 96165, 96167, & 96168 (and any successor codes)

EXPANDING INTENSIVE OUTPATIENT PROGRAM (IOP) SERVICES

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Change

- IOP may be furnished by hospitals, Community Mental Health Centers (CMHCs), FQHCs, and RHCs.
- Payment for IOP services furnished by RHCs and FQHCs is same payment rate as hospital.
- Current Conditions of Participation (CoP) require CMHC must provide at least 40% of its services to individuals who are not eligible for Medicare Part B (or their Medicare enrollment will be denied or revoked)
- Services include occupational therapy, family counseling, beneficiary education, diagnostic services and individual and group therapy
- Add-on code for IOP services furnished by OTPs for the treatment of opioid use disorder and to revise the definition of opioid use disorder treatment services to include IOP services.

Implications for Clinical Practice

- ✓ **CMHC, FQHC, and RHC expand access to reimbursable mental health care to Medicare patients**
- ✓ **For first time in history, FQHCs IOP mental health benefit will be paid for under the Medicare Outpatient Prospective Payment System**
- ✓ **More options for people to get OTP services that are accessible and integrated into their primary care.**
- ✓ **Requires that an FQHC or RHC physician certify that a patient needs IOP and IOP certification rules are met.**
- ✓ **Will NOT pay for an IOP service on the same day as an FQHC or RHC "mental health visit," but will pay for IOP services and an FGHC or RHC medical visit.**

CHANGING PAYMENT STRUCTURE

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Change

- Codifies the payment amounts for CSW, MFT, and MHC services at 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for CP services under the Physician Fee Schedule (PFS).

- Applies an adjustment to the work RVUs for the time-based psychotherapy codes* (90832, 90834 etc., incl new GPFC1 and GPFC2 codes) payable under the PFS using an inherent complexity add-on code (HCPCS code G2211)
  - 9.1% adjustment over 4-year transition

Implications for Clinical Practice

- ✓ **Developing pro formas that maximize clinical expertise with the proposed payment structure**

- ✓ **Training billing and coding staff to understanding what CPT codes are ineligible**

*CPT codes 90833, 90836, and 90838 are ineligible because they are add-on codes for psychotherapy performed at an evaluation and management (E/M) visit

EXPANDING TELEHEALTH

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Change

- RHC and FQHC mental health visits can also include encounters through interactive, real time, audio/video telecommunications technology or audio-only in cases where patients are not capable of, or do not consent to the use of devices that permit a two-way, audio/video interaction for the purposes of diagnosis, evaluation, or treatment of a mental health disorder
- Payment is same as in real time visits
- *Effective January 1, 2025- Must be an in-person mental health service within 6 months PRIOR to the telecommunications service AND an in-person service at least once every 12 months while receiving services UNLESS physician or practitioner and patient agree the risks and burdens outweigh the benefits (documenting this decision in the medical record)*

Implications for Clinical Practice

- ✓ **Gives reimbursement flexibility to telehealth visits for patients with limited access or other issues prohibit two-way audio/video interaction**
- ✓ **Planning for the 6 month and within 12 months rule component effective January 1, 2025.**

IMPROVING MOBILE CRISIS IN MEDICARE

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Change

- New HCPCS codes under the PFS for psychotherapy for crisis services furnished in an applicable site of service [any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting]
- GFPC1 first 60 min, GPFC2 each additional 30 min; list separately in addition to code for primary
- Payment is equal to 150% of the fee schedule amount for non-facility service sites
- Peer Support Specialists are able to bill under these codes as well but must be under supervisor of a physician (or other practitioner)

Implications for Clinical Practice

- ✓ **Covers psychotherapy for crisis services that can be billed when the services are furnished in any non-facility place of service other than the physician's office setting**
- ✓ **Also, services may be reimbursed by provided by auxiliary personnel (e.g., Nurses, peer support specialists)**

EXPANDING HOSPICE INTERDISCIPLINARY TEAM

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Change

- Hospice programs are required to have an interdisciplinary team with at least one social worker, MFT, or MHC

Implications for Clinical Practice

✓ **Increased use of SW, MFT or MHC in hospice settings – improving outcomes, increasing opportunities, but also potentially increasing BH workforce demands.**

PREVENTIVE PRIMARY SERVICES

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Change

- Furnished by a or under the direct supervision of a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, clinical social worker, marriage and family therapist, or mental health counselor employed by or under contract with the FQHC
- Must be performed in accordance with state law
- Includes services and supplies furnished as an incidental although integral part of the professional services provided by a CP, CSW, MFT, or MHC

Implications for Clinical Practice

✓ **Creates opportunity to design workflows and care plans that are include more team members employed by or under contract with the FQHC who can provide preventative services**

NEW RULES FOR SERVICES "INCIDENT TO" A VISIT

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Change

Behavioral health services provided in RHC and FQHC settings no longer require direct supervision of a physician or Non-Physician Practitioner (NPP) but rather general supervision.

- General supervision means the service is furnished under the physician's (or other practitioner's) overall direction and control, but the physician's (or other practitioner's) presence is not required during the performance of the service.

3 New Proposed "Incident To" Services:

- Community Health Integration
- Administration of a standardized SDOH tool
- Principle Illness Navigation (PIN)

Implications for Clinical Practice

- ✓ **Greater ease and confidence of administration of "incident to" services.**
- ✓ **Increased use of NP practitioners in PC settings, including peers.**

WORKFORCE / RECRUITING / CREDENTIALING IMPACTS

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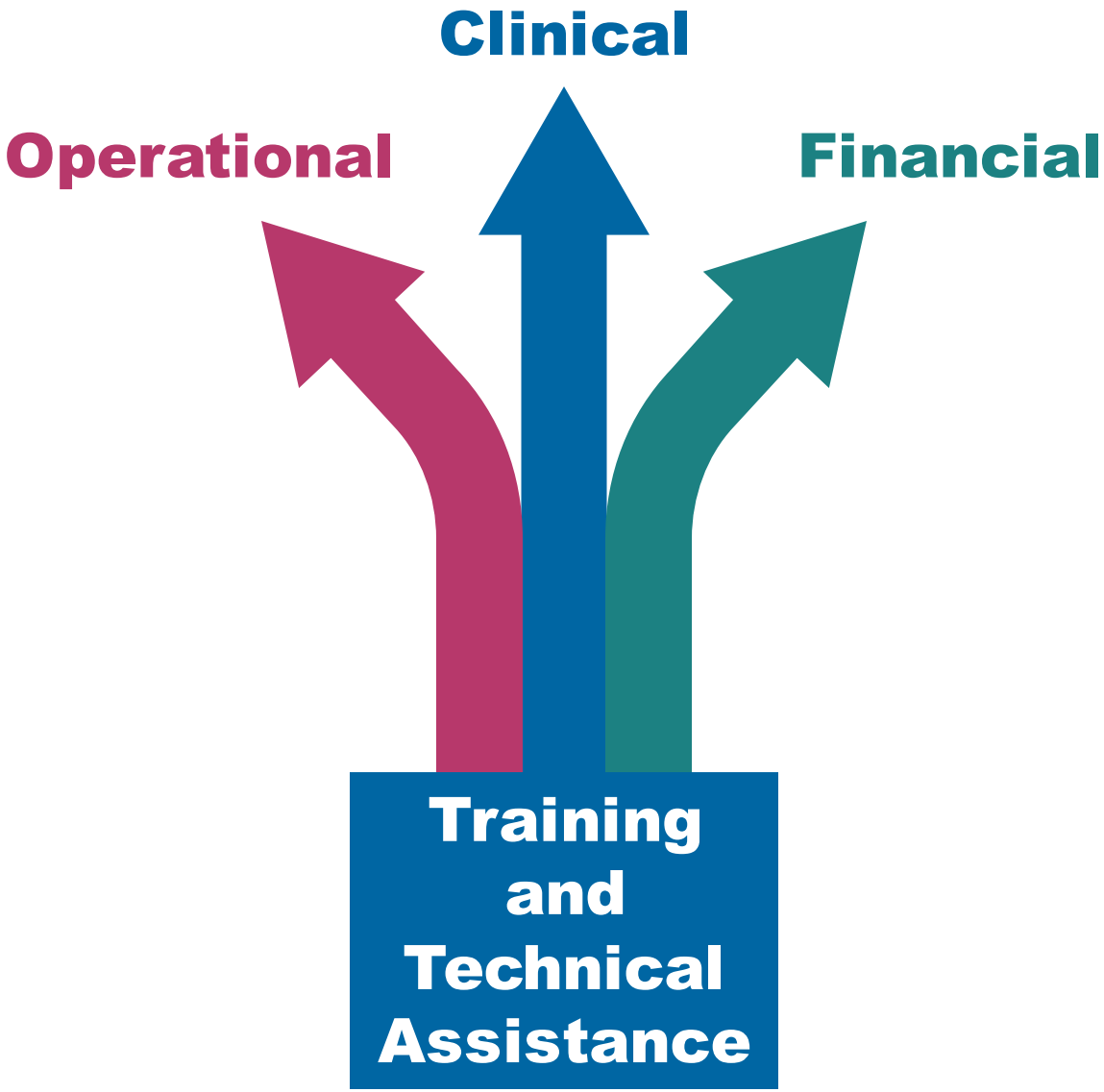
Change

- MFTs and MHCs will need to complete, sign, and submit Form CMS-855 to enroll in the Medicare Program and obtain Medicare billing privileges.
- Proposed that MFTs and MHCs not be subject to only limited risk screening.
- Applications can be submitted after the CY 2024 PFS final rule is published BUT the new benefit categories will NOT take effect until January 1, 2024.
- Any claims submitted for dates prior to that will not be payable

Implications for Clinical Practice

- ✓ **Human Resource Officers and Departments revising job descriptions and position titles to be more inclusive**
- ✓ **Building multidisciplinary teams that address whole person needs using best practice interventions, team-based care strategies, active collaboration, and accessible documentation to reduce fragmentation**
- ✓ **Recruiting for expertise and experience versus a billable license only**

...ALL THIS TRANSLATES INTO A NEED FOR ADDITIONAL TRAINING AND TECHNICAL ASSISTANCE FOR ALL PARTS OF THE SYSTEM



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KEY TAKEAWAYS

- CMS Medicare rule changes create opportunities to train and engage the healthcare workforce to work more collaboratively with sustainable real-world models
- Integrated care services will be more accessible to more people
- Greater opportunities to utilize technology to engage patients in care beyond telehealth services
- Expansion of mental health service coverage (including SUD and crisis care), meeting patients where they are at and reducing stigma and barriers to care
- Addressing behavioral health workforce shortage issues by permitting more federally recognized core mental health disciplines to apply for Medicare reimbursement of their services.

You have the option to submit comments on these changes and upcoming considerations. We can help!

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WHAT CAN WE DO FOR YOU?

Our depth and breadth of experience has helped an incredibly diverse range of healthcare industry leaders.

Questions?

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WEBINAR FOLLOW-UP: Q & A

Question	Answer
Will the changes CMS is making to telehealth services allow for provider and patient to not be in the licensed program space? Including for partial hospitalization programs?	At this time, it is unclear of the exact policy specifications.
You mentioned opportunities for the community to share feedback with CMS, how do we learn more about how to contribute and access feedback opportunities with CMS? Is it local/national?	DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on September 11, 2023. ADDRESSES: In commenting, please refer to file code CMS-1784-P. Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed): 1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the "Submit a comment" instructions. 2. By regular mail. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1784-P, P.O. Box 8016, Baltimore, MD 21244-8016.Here
If counseling can occur via telehealth, and a treatment plan is completed or a review of a treatment plan, the patient is not available for a signature that day the service was provided, will Medicare still pay for the service provided?	Policy details are not yet clear on payment specifics.
Any expansion for home health care. (i.e. LMHC) How about OTs?	No, not at this time.
Is this specific to the changes associated with the 2024 PFS Proposed Rule? Or are there pieces of this that are not linked to the 2024 PFS Proposed Rule?	We were covering the proposed changes to the 2024 PFS Proposed Rule.

WEBINAR FOLLOW-UP: Q & A

Question	Answer
Do you know if Medicare will expand coverage of "H" codes billed by providers?	No, these are not recognized by Medicare.
Will providers bill Medicare directly or will new codes be available in CMH or PIHP network contract?	For Medicare FFS, these Medicare enrolled providers will bill Medicare directly.
If the in-person requirement is enforced and the BH service is across state lines, how is that handled? Via the PCP?	Licensing and certification is the prevue of States rather than Federal/Medicare – and thus is out of scope of this discussion.
For the HRSA workforce projections that you reviewed, was that data specific to behavioral health? And did this projection include changes resulting from these CMS rules?	The workforce projection data was from HRSA and was specific to behavioral health on the slide where were we discussed supply and demand by 2035. The project did not include changes made by CMS but what we are hoping to avoid happening because of the changes by CMS, including more licensed mental health disciplines in Medicare reimbursement.
Could you provide further clarification on what the "general supervision" is as it relates to supervisor presence. What additional flexibility does this allow for supervisors and are there any limitations that supervisors should be aware of?	"General supervision" means the definition specified at 42 CFR 410.32(b)(3)(i), that is, the procedure or service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.
Will reimbursement rates increase?	The payment rate for any particular services is based on a variety of factors. The payment for some services is increasing because CMS proposed to increase their value. Overall, there is no automatic update to payments under the Physician Fee Schedule. In addition, the current statutory requirement is for there to be a negative update to the conversion factor.
Is there any support in loan forgiveness for clinicians employed in OTP? I think if there was more incentives for clinicians, we would have less shortage.	That is a great question, and we agree. Here is a resource that may be helpful in answering your question: https://crsreports.congress.gov/product/pdf/IF/IF12184