Medicare Access Coalition

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# Medicare Coverage of Mental Health Counselors and Marriage and Family Therapists


**Summary**

Medicare beneficiaries should have access to mental health counselors and marriage and family therapists (MFTs).


**Highlights**

- The House and Senate have twice passed legislation recognizing mental health counselors and MFTs as Medicare providers since 2003, but never consecutively.
- Mental health counselors and MFTs are both licensed in all 50 states to provide independent mental health services and should not be unavailable to the elderly once they turn 65 years old.
- Mental health counselors and MFTs are prevalent in rural areas and can expand access to many Medicare beneficiaries who don't currently have a mental health professional available to them.

**Status**

Medicare is the largest health care program in the country, covering over 49 million Americans. The elderly and disabled in the Medicare program are often at the highest risk for mental health problems such as depression and suicide. Despite the high rates of mental disorders, many Medicare beneficiaries do not have access to a mental health professional because of their remote locations and the shortage of mental health providers.

Medicare presently recognizes psychiatrists, psychologists, clinical social workers and psychiatric nurses to provide covered mental health services. Mental health counselors and MFTs have equivalent education and training to clinical social workers, but are not eligible to serve Medicare beneficiaries. Recognition of mental health counselors and MFTs would increase the pool of eligible mental health professionals by over 200,000 licensed practitioners.

Mental health counselors and MFTs are well qualified to provide covered mental health benefits. Mental health counselors and MFTs must obtain a master's or doctoral degree in counseling, two years postgraduate supervised experience, and pass a national exam to obtain a license to practice independently. All fifty states license mental health counselors and MFTs to diagnose and treat mental and emotional disorders. Many federal programs already recognize mental health counselors and MFTs, including the National Health Service Corps, the Department of Veterans Affairs, and TRICARE.

Both chambers of Congress have supported Medicare recognition of counselors and MFTs. The U.S. Senate passed legislation in 2003 (S. 1) and 2005(S. 1932), and the House passed legislation in 2007 (HR. 3162) and 2009 (H.R. 3962). Eight bills from the 111th Congress included language to accomplish this goal. The five year estimated cost of 100 million dollars is negligible in the context of Medicare expenditures and does not reflect any cost offset savings.

Medicare beneficiaries need more mental health services, particularly in rural and underserved areas. Mental health counselors and MFTs are trained to serve these populations and are geographically accessible. The time has come to give all Medicare beneficiaries access to a qualified professional by recognizing counselors and MFTs in the Medicare program.

**Recommendation**

Congress should pass legislation recognizing mental health counselors and MFTs as covered Medicare providers.

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# Medicare and Mental Health

Medicare beneficiaries have serious mental health challenges. The elderly experience mental disorders that are not part of normal aging, including anxiety, severe cognitive impairment, and mood disorders. The rate of suicide is highest among older adults compared to any other age group – and the suicide rate for persons 85 years and older is the highest of all – twice the overall national rate. Access to a mental health professional is one of the primary impediments to good behavioral health care.

**Need for MHC and MFT Medicare Recognition**

- **Elderly Mental Health Problems** – Several recent reports have indicated that limited access to mental health services is a serious problem in the Medicare program. According to a recent Surgeon General's report, 37% of seniors display symptoms of depression in a primary care environment.

- **Comparable Education** – The covered mental health professionals recognized by Medicare presently include psychiatrists, psychologists, mental health clinical nurse specialists, and clinical social workers. MHCs and MFTs are not listed as Medicare-covered providers despite the fact that both groups have education, training, and practice rights equivalent to or greater than existing covered providers.

- **Lack of Access** – Approximately 77 million people live in 3,000 mental health professional shortage areas. Fully 50 % of rural counties in America have no practicing psychiatrists, psychologists, or social workers. Research shows that MHCs and MFTs are located in many rural and underserved areas that do not have any of the current Medicare providers.

- **Medicare Inefficiency** – Inpatient psychiatric hospital utilization by elderly Medicare recipients is extraordinarily high when compared to psychiatric hospitalization rates for patients covered by Medicaid, VA, TRICARE, and private health insurers. One third of these expensive inpatient placements are caused by clinical depression and addiction disorders which can be treated for much lower costs when detected early through the outpatient mental health services of MHCs and MFTs. Studies conducted by CMS show Medicare is spending on average $9,000 per inpatient mental health claimant and only $400 per outpatient mental health claimant. Medicare's greater ratio of spending on inpatient mental health versus outpatient mental health is the inverse of mental health purchases exercised by other insurers, including Medicaid and private insurers.

- **Costs** – The addition of MHCs and MFTs should save money over time. The CBO cost is $100 million over five years/$400 million over ten years, but these do not include any cost offsets. Our proposal proposes to pay MHCs and MFTs only 75% of the psychologist's rate for mental health services, thereby saving money when the lower cost provider is accessed. This legislation would not change the Medicare mental health benefit or modify the MHC or MFT scope of practice, but instead allow seniors access to the high quality "medically necessary" mental health care services of MHCs and MFTs.

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# Legislative History of Medicare Coverage of Mental Health Counselors (MHCs) and Marriage and Family Therapists (MFTs)

107th Congress (2001-2002)

The provision to provide reimbursement for MHCs and MFTs in the Medicare program was introduced as standalone bill **S. 1760** by Sen. Craig Thomas (R-WY) and Sen. Blanche Lincoln (D-AR). The companion bill **H.R. 3899** was subsequently introduced on the House side by Rep. Brad Carson (D-OK). The same provision was additionally included in an omnibus Medicare mental health bill (**S. 690** and **H.R. 1522**), but did not make it out of committee.

108th Congress (2003-2004)

Sen. Craig Thomas (R-WY) introduced **S. 310** as a standalone bill. The language was also included in the omnibus Medicare mental health bill (**S. 646**) and the omnibus Medicare rural access bill (**S. 1185** and **H.R. 2333**). In 2003, **the provision passed the Senate in the Medicare prescription drug bill (S. 1)**, but was not accepted during conference.

109th Congress (2005-2006)

In addition to companion bills **S. 784** and **H.R. 5324**, introduced by Sens. Thomas/Lincoln and Rep. Barbara Cubin (R-WY), the MHC and MFT provision was again included in the omnibus Medicare mental health bill (**S. 927** and **H.R. 1946**) and the Medicare rural access bills (**S. 3500** and **H.R. 6030**). **The provision passed the Senate as part of the Deficit Reduction Act of 2005 (S. 1932)**, but did not make it through conference.

110th Congress (2007-2008)

Companion standalone bills **S. 921** and **H.R. 1588** were introduced by Sens. Thomas/Lincoln and Rep. Cubin. Rep. Pete Stark (D-CA) and included the MHC and MFT language in his omnibus Medicare mental health bill (**H.R. 1663**). **The provision passed the House as part of the SCHIP Reauthorization Act (H.R. 3162)**. The Senate declined to consider the SCHIP bill.

111th Congress (2009-2010)

The provision was re-introduced in companion standalone bills **S. 671** and **H.R. 1693** by Sens. Blanche Lincoln (D-AR)/John Barrasso (R-WY) and Rep. Bart Gordon (D-TN). The provision was included in **H.R. 3200**, the House reform legislation that passed the Energy and Commerce, Ways and Means, and Education and Labor Committees. **The language passed the House as part of the health reform bill (H.R. 3962)**. The provision was reportedly in the final House-Senate compromise legislation until the election of Sen. Scott Brown (R-MA) changed the Senate balance.

112th Congress (2011-2012)

Sen. Ron Wyden (D-OR) introduced standalone bill **S. 604**, the Seniors Mental Health Access Improvement Act of 2011. The MHC and MFT language was also included in **S. 1680**, the Craig Thomas Rural Hospital and Provider Equity Act of 2011, introduced by Sens. Barrasso, Pat Roberts (R-KS), Kent Conrad (D-ND) and Tom Harkin (D-IA).

113th Congress (2013-2014)

Sens. Wyden, Barrasso, and Merkley (D-OR), introduced a standalone bill **S. 562**, the Seniors Mental Health Access Improvement Act of 2013. Reps. Gibson (R-NY) and Thompson (D-CA) introduced **H.R.3662** as a companion to S. 562. The Medicare provision is included in a House comprehensive mental health bill, **H.R. 4574**, introduced by Rep. Barber (D-AZ), the Senate Rural Healthcare Caucus bill, **S. 2359,** introduced by Sens. Franken (D-MN), Roberts (R-KS), Harkin (D-IA) and Barrasso (R- WY) and the House

TriCaucus health disparities bill, **H.R. 5294**, introduced by Rep. Roybal-Allard (D-CA).

114th Congress (2015-2016)

Companion standalone bills **S. 1830** the Seniors Mental Health Access Improvement Act of 2015 and **H.R. 2759** the Mental Health Access Improvement Act were introduced by Sens. John Barrasso ( R-WY) and Debbie Stabenow (D-MI) and Reps. Chris Gibson (R-NY) and Mike Thompson (D-CA). The House TriCaucus health disparities bill, **H.R. 5475**, was introduced by Rep. Robin Kelly (D-IL). Sens. Roberts (R-KS), Franken (D-MN), Barrasso (R-WY), and Heitkamp (D-ND) introduced the Craig Thomas Rural Hospital and Provider Equity Act of 2016, **S.3435**.

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# Medicare Standards for Licensed Mental Health Counselors, Licensed Clinical Social Workers, and Licensed Marriage and Family Therapists

Social Security Act §1861(hh)(1) sets out the education, experience, and licensure requirements for mental health professionals' participation in Medicare. Clinical social workers are recognized as Medicare providers, but mental health counselors and marriage and family therapists are not. The text below is taken directly from Social Security Act §1861(hh)(1) for social workers and the legislation adding mental health counselors and marriage and family therapists to the law.

| | Licensed Clinical Social Worker | Licensed Mental Health Counselor | Licensed Marriage and Family Therapist |
|---|---|---|---|
| **Current Medicare Provider:** | Yes | No | No |
| **Education:** | Possesses a master's or doctoral degree in social work | Possesses a master's or doctoral degree in mental health counseling or a related field | Possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law |
| **Experience:** | Two years of post-graduate supervised clinical social work experience | Two years of post-graduate supervised mental health counselor practice | Two years of post-graduate clinical supervised experience in marriage and family therapy |
| **Licensure Requirement:** | Licensed or certified to practice as a clinical social worker by the State in which the services are performed | Licensed or certified as a mental health counselor within the State of practice | Licensed or certified as a marriage and family therapist within the State of practice |
| **State Licensed Providers:** | 193,000 | 144,500 | 62,300 |

**Bending the Cost Curve: Increasing Medicare's Outpatient Spending to Decrease its Inpatient Spending**

There is significant evidence to support the conclusion that by shifting Medicare's mental health spending from inpatient to outpatient services, Congress could save significant funds. An immediate investment of $200 million over five years to cover services provided by licensed professional counselors and marriage and family therapists would grant beneficiaries access to over 160,000 mental health providers and decrease inpatient spending in the future.

Older Americans (65+) have higher rates of mental illness and suicide than any other demographic but are also the least likely to seek services, with only one in five receiving needed therapy from a mental health professional. Older Americans also have the highest rates of mental health related hospitalizations (*Health Affair*s, May-June 2009). Finally, mental illness is the most common (35%) qualification for individuals with disabilities—the other Medicare-eligible population.

This all leads to higher inpatient spending under Medicare than any other health care provider. Medicare spends approximately four times as much on inpatient and institutional outpatient services ($4.5 billion in 2002) as on physician/supplier services ($1.2 billion in 2002) for its mental health claimants. Inpatient services constitutes 73% of total spending for mental health claimants, but serve just 10% of claimants, while outpatient spending constitutes just 19% of spending and serves 92% of claimants. In 2002, this resulted in a cost of $9,660 per inpatient claimant versus just $342 per outpatient claimant.

Mental illnesses also result in increased spending for physical ailments. In 2004, Medicare spent a total of $62.8 billion for services to mental health claimants, of which less than $10 billion was for MH/SA services. Not surprisingly, a January 2009 study in the *Journal of the American Geriatric Society* found that Medicare beneficiaries with a diagnosis of depression in addition to a chronic physical illness cost the program nearly twice as much as beneficiaries with a chronic illness but no depression. One epidemiological study found that chronic depression increases the risk of cancer by 88% in older Americans (*Mental Health: A Report of the Surgeon General*, 1999).

Congress can "bend the cost curve" by spending money for the right services. A study of private insurance recipients' mental health care purchases found that increased availability of outpatient treatment for mild or moderate mental health disorders, such as depression, resulted in a $2,307 per patient (30%) decrease in mental health care costs (*American Journal of Psychiatry,* 1999). By covering professional counselors and marriage and family therapists, Medicare can take advantage of those savings—increasing availability of outpatient treatment and cutting spending at the same time.

## Table 4. Estimate of the Effects on Direct Spending and Revenues of Divisions B, C, and D and Sections 111, 115, and 346 of H.R. 3962, the Affordable Health Care for America Act, Incorporating the Manager's Amendment Offered by Representative Dingell

*By Fiscal Year, in Billions of Dollars*

| | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2010-2014 | 2010-2019 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | 0 | 0 | * | * |
| With Limited English Proficiency | 0 | * | * | * | * | * | 0 | 0 | 0 | 0 | * | * |
| | | | | | | | | | 0 | 0 | 0 | 0 |
| | | | | | | | | | 0 | 0 | 0 | 0 |
| | | | | | | | | | 0 | 0 | 0.9 | 0.9 |
| Drugs and Other Renal Dialysis Provisions | 0 | * | * | * | * | * | * | * | * | * | * | -0.1 |
| | | | | | | | | | 3 | 0.3 | 0.7 | 2.0 |
| Enrollment Penalty for TRICARE Beneficiaries | * | * | * | * | * | * | * | * | * | * | * | * |
| Gains From Sale of Primary Residence in Computing Part B Income-Related Premium | * | * | * | * | * | * | * | * | * | * | * | * |
| | | | | | | | | | * | * | * | * |
| | | | | | | | | | 7 | -0.8 | -0.2 | -2.6 |
| | | | | | | | | | 0 | 0 | 1.5 | 1.8 |
| | | | | | | | | | 6 | 0.7 | 1.8 | 4.7 |
| | | | | | | | | | * | * | * | * |
| Preventive Services | 0.1 | 0.2 | 0.2 | 0.2 | 0.3 | 0.3 | 0.3 | 0.3 | 0.4 | 0.4 | 1.0 | 2.7 |
| | | | | | | | | | 0 | 0 | 0 | 0 |
| Under the Medicare Skilled Nursing Facility Prospective Payment System and Consolidated Payment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mental Health Counselor Services | * | * | * | * | * | * | 0.1 | 0.1 | 0.1 | 0.1 | 0.1 | 0.4 |
| Add-On | * | * | * | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.1 | 0.1 |
| | | | | | | | | | 3 | 0.4 | 0.2 | 1.5 |
| Federally Qualified Health Centers | * | * | * | * | * | * | * | * | * | * | 0.1 | 0.1 |
| | | | | | | | | | 0 | 0 | * | * |
| | | | | | | | | | * | * | * | * |

# County-Level Estimates of Mental Health Professional Supply in the United States

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Kathleen C. Thomas, M.P.H., Ph.D.
Joseph P. Morrissey, Ph.D.

***Objective:*** **This study compiled national county-level data and examined the geographic distribution of providers in six mental health professions and the correlates of county-level provider supply.** ***Methods:*** **Data for six groups—advanced practice psychiatric nurses, licensed professional counselors, marriage and family therapists, psychiatrists, psychologists, and social workers—were compiled from licensing counts from state boards, certification counts from national credentialing organizations, and membership counts from professional associations. The geographic distribution of professionals was examined with descriptive statistics and a national choropleth map. Correlations were examined among county-level totals and between provider-to-population ratios and county characteristics.** ***Results:*** **There were 353,398 clinically active providers in the six professions. Provider-to-population ratios varied greatly across counties, both within professions and overall. Social workers and licensed professional counselors were the largest groups; psychiatrists and advanced practice psychiatric nurses were the smallest. Professionals tended to be in urban, high-population, high-income counties. Marriage and family therapists were concentrated in California, and other mental health professionals were concentrated in the Northeast.** ***Conclusions:*** **Rural, low-income counties are likely candidates for interventions such as the training of local clinicians or the provision of incentives and infrastructure to facilitate clinical practice. Workforce planning and policy analysis should consider the unique combination of professions in each area. National workforce planning efforts and state licensing boards would benefit from the central collection of standardized practice information from clinically active providers in all mental health professions. (*Psychiatric Services* 60: 1315–1322, 2009)**

Of approximately $100 billion spent annually on U.S. mental health care, about 70% pays for the labor of mental health professionals (1). Yet we lack valid and reliable workforce data, and academic research rarely focuses on the mental health workforce (2). A workforce crisis currently affects diverse areas—recruitment, retention, training and technical assistance, compensation, career advancement, and geographic distribution (2)—making the need for comprehensive workforce data even more critical.

Various workforce reports can be found in the literature, but none provides a detailed national picture of the mental health professions. Prior studies have described the characteristics, needs, and practice patterns of the national mental health workforce and compared the professions (3; also unpublished documents: "Practitioner Research Network: Summary of Initiative and Findings," Substance Abuse and Mental Health Services Administration [SAMHSA], Center for Substance Abuse Treatment [CSAT]; "Practitioner Services Network II Initiative: Summary of Findings," SAMHSA, CSAT, 2003), discussed how rural workforce needs have been and could be addressed (4), assessed the effects of licensure laws on workforce availability (5), examined cross-sectional data on individual professions (6–9), and conducted within-state, small-area analyses (10,11). This study built on this literature by compiling national county-level data to examine the geographic distribution of providers in six mental health professions and the correlates of county-level provider supply. Our main goal was to present profiles that would be useful for workforce planning at local, state, and national levels. A secondary goal was to provide information about the availability and comprehensiveness of existing workforce data to the research and practice communities. Further information is provided in two companion articles in this issue exploring

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county-level need for and shortages of mental health professionals in the United States (12,13).

## Methods

### *Data sources*

Because this study was part of a project involving the designation of shortage in the mental health profession (14), which is a responsibility of the Health Resources and Services Administration (HRSA), we used HRSA's definition of "mental health professionals": advanced practice psychiatric nurses, licensed professional counselors, marriage and family therapists, psychiatrists, psychologists, and social workers. Although other professionals and nonprofessionals contribute significantly to mental health services, these six groups constitute a majority of mental health professionals, and information about them is critically important for mental health policy and planning. Our goal was to count clinically active providers (specifically, those who are actively engaged in the diagnosis and treatment of mental disorders) rather than the larger population of clinically trained providers (those who have been trained at the master's or doctoral level to perform these functions).

We explored several potential data sources (see below). Their advantages and disadvantages are summarized in a table available as an online supplement to this article at ps.psychiatryonline.org. The typical tradeoff is between coverage (for example, national scope or inclusion of multiple professions) and identification of the correct group of providers. The Bureau of Labor Statistics has employer-reported data on psychiatric nurses, family therapists, psychiatrists, psychologists, and social workers, but these data are limited by aggregation to the state or metropolitan statistical area (MSA) level, lack of information on professional degree, failure to distinguish among professions, and exclusion of self-employed providers.

Census data and the Area Resource File (15) are easily accessible national data sets that contain counts of nurses, psychologists, and social workers. However, they do not cover areas with populations under 50,000, indicate professional degree, or distinguish between clinical and other specialties.

For most professions, state licensing data would yield the best counts of clinically active providers, because licensure is usually required for clinical practice and is not trivial to maintain. However, licensing data are difficult to obtain because they are not centrally collected, are often confidential, and are maintained by state boards, many of which have few resources. Also, licensing data are not standardized, may not include provider specialty, and may include the same individual in multiple professions or states.

Certification and professional association membership data are national in scope but yield undercounts of clinically active providers because membership is voluntary and certification is not required for most professions and states (especially where licensure is required). Also, membership data often do not indicate provider specialty.

Licensing, certification, and especially membership data include some inactive practitioners, who generally cannot be distinguished from clinically active providers. Licensing data may be less affected by this limitation because of renewal and continuing education requirements. Most data sets from any source lack consistent, up-to-date information on practice locations, do not incorporate multiple practice locations, and do not distinguish between home and work addresses.

### *Data collection*

Considering the data source characteristics, we preferred licensing data where available, then membership data, then certification data. Therefore, we combined licensing counts from state boards, certification counts from national credentialing organizations, and membership counts from professional associations, always choosing the most preferred data source available for a given state and profession. These data were difficult to obtain but allowed us to estimate with reasonable accuracy the number of clinically active providers in each profession at the county level. Also, we were able to use some multistate licensing data previously assembled by others.

Even when counts were available at the zip code level, they were aggregated to the county level because a zip code could be associated with either a practice location or a home address, likely making the county-level counts a less error-prone approximation of practice locations. Aggregation also made the counts comparable across professions, because counts of marriage and family therapists were not available below the county level. Furthermore, whereas zip codes were designed for mail delivery, county boundaries are a meaningful basis for mental health service planning, which is often done for counties or county groups. Although zip code areas are often nested within counties, this is not always the case; therefore, a table of approximate zip-to-county conversions was used.

For nurses we used psychiatric nursing certification data provided in 2003 by the American Nurses Credentialing Center. Zip-level counts were generated and were converted to county-level counts by using the table of approximate zip-to-county associations. Membership data were not used for nursing because the American Nurses Association does not record specialty and the American Psychiatric Nurses Association has data for only a subset of psychiatric nurses.

For licensed professional counselors, the American Counseling Association (ACA) provided licensing information for 38 states. For the other 13 states, certification data from the National Board of Certified Counselors Web site were used. Zip-level counts were converted to county-level counts.

Similarly, for marriage and family therapists, the American Association of Marriage and Family Therapists provided county-level counts based on licensing data where available (26 states) and on clinical membership otherwise (25 states).

For psychiatrists, data from the American Medical Association's (16) Physician Masterfile in regard to individual general psychiatrists were used. Residents and those not treat-

# MENTAL HEALTH ACCESS IMPROVEMENT ACT OF 2015 (S. 1830/H.R. 2759)

## INCREASING PATIENTS' ACCESS TO BEHAVIORAL HEALTH PROVIDERS

In July 2015, Senators John Barrasso (R-WY) and Debbie Stabenow (D-MI), with Representatives Christopher Gibson (R-NY) and Mike Thompson (D-CA), introduced the Mental Health Access Improvement Act of 2015 (S. 1830/H.R. 2759). This legislation would allow marriage and family therapists (MFTs) and licensed mental health counselors to directly bill Medicare for their services. Currently, these professionals are not permitted to directly bill Medicare, despite the important role they play in delivering services to seniors and people with disabilities, particularly in underserved, rural areas with a mental health workforce shortage. This simple change would immediately increase patients' access to needed care in their communities. Additionally, the National Council and Hill Day partners support adding language that would ensure patients' access to counselors who have undergone specialized training, credentialing, and licensure to provide addiction treatment.

## WHY DO WE NEED THE MENTAL HEALTH ACCESS IMPROVEMENT ACT?

### OLDER AMERICANS HAVE HIGH RATES OF MENTAL ILLNESS AND SUICIDE, YET HAVE LOWER RATES OF TREATMENT THAN OTHERS.

Individuals age 65 and older have the highest rates of mental health related hospitalizations and a suicide rate that exceeds the rest of the population. Yet, they are the least likely to receive mental health services, with only one in five receiving needed therapy. Allowing additional providers to serve Medicare enrollees with behavioral health disorders offers a remedy for this lack of access to care.

### MFTS AND COUNSELORS PRACTICE IN AREAS WITHOUT ACCESS TO OTHER MEDICARE-COVERED PROFESSIONALS.

With 77 percent of U.S. counties experiencing a severe shortage of behavioral health professionals, over 80 million Americans live in areas that lack sufficient providers. According to the Substance Abuse and Mental Health Services Administration, fully half of all U.S. counties have no practicing psychiatrists, psychologists, or social workers. Many of these rural and underserved areas without any current Medicare providers do have practicing MFTs and/or mental health counselors, including counselors who have been trained and licensed to provide addiction services.

### EXPANDING THE WORKFORCE POOL WOULD EXPAND PATIENTS' ACCESS TO TREATMENT.

Allowing previously ineligible providers to directly bill Medicare for their services would immediately alleviate the strain on our nation's mental health and addiction workforce serving Medicare enrollees. This legislation would not change the Medicare mental health benefit or modify states' scope of practice laws but would instead allow Medicare enrollees access to medically necessary covered services provided by mental health and addiction professionals who are properly trained and licensed to deliver such services.

### COUNSELORS AND MFTS HAVE SIMILAR TRAINING AND LICENSURE STANDARDS TO SIMILAR PROVIDERS ALREADY INCLUDED WITHIN MEDICARE.

MFTs and licensed mental health counselors must obtain a master's or doctoral degree, two years post-graduate supervised experience, and pass a national exam to obtain a state license, requirements comparable those placed on Medicare-covered clinical social workers. Counselors and MFTs can also go through additional training to become certified as addiction specialists. All fifty states license these professionals, and their services are covered by other federal programs like TRICARE and the Veterans Administration.

### CONGRESS HAS LONG SUPPORTED THIS CHANGE.

Legislation to include MFTs and mental health counselors in Medicare has won bipartisan support over seven past Congresses and was passed in either the full House or Senate on four separate occasions.

## REQUEST

PLEASE COSPONSOR THE MENTAL HEALTH ACCESS IMPROVEMENT ACT OF 2015 (S. 1830/ H.R. 2759).

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
Healthy Minds. Strong Communities.

ABHW Association for Behavioral Health and Wellness · ARS Recovery Schools · DBSA Depression and Bipolar Support Alliance · Faces & Voices of Recovery · Hazelden Betty Ford Institute for Recovery Advocacy · international bipolar foundation A world of hope, resources and support · Legal Action Center · MHA Mental Health America · NAADAC NAADAC.ORG · NAMI National Alliance on Mental Illness · The Network for Social Work Management · PRA Psychiatric Rehabilitation Association · YPR

# MENTAL HEALTH ACCESS IMPROVEMENT ACT 2015

*CURRENT AS OF 5/26/16*

## COSPONSORS

H.R. 2759

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CA: Pete Aguilar (D-31)

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S. 1830

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*Lead Sponsor*

ABHW

Association for Behavioral Health and Wellness

*Advancing benefits and services in mental health, substance use and behavior change.*

October 13, 2015

The Honorable Christopher Gibson
United States House of Representatives
1708 Longworth House Office Building
Washington, DC 20515

The Honorable Mike Thompson
United States House of Representatives
231 Cannon House Office Building
Washington, DC 20515

Dear Congressman Gibson and Congressman Thompson:

The Association for Behavioral Health and Wellness (ABHW) expresses our support for H.R. 2759, the Mental Health Access Improvement Act of 2015. We thank you for your leadership on the issue of recognizing more mental health providers under Medicare.

ABHW is the national voice for companies that manage behavioral health and wellness benefits. ABHW member companies provide specialty services to treat mental health, substance use, and other behaviors that impact health to approximately 150 million people in both the public and private sectors. ABHW and its member companies use their behavioral health expertise to improve health care outcomes for individuals and families across the health care spectrum.

ABHW believes Medicare should begin to cover additional provider types that are currently excluded from reimbursement. Despite high rates of mental health disorders, many Medicare beneficiaries do not have access to a mental health professional because of their remote locations and the shortage of mental health providers. In order to increase the array of providers available to Medicare beneficiaries and to decrease the workforce shortage, ABHW agrees that Medicare should recognize mental health counselors and marriage and family therapists.

As the House Energy and Commerce Committee turns its focus toward mental health reform this year, it is our hope that it will consider including your legislative language as a provision in the Committee's final bill. Expanding the pool of eligible mental health professionals by over 165,000 licensed practitioners would certainly play a significant role in increasing access to care and reforming our country's mental health system.

We look forward to continuing to work with your office on this and other mental health legislation. If you have any questions, please contact me at (202) 449-7660 or greenberg@abhw.org.

Sincerely,

Pamela Greenberg

Pamela Greenberg,
President and CEO, ABHW

February 4, 2014

The Honorable Ron Wyden
221 Dirksen Senate Office Building
Washington, DC 20510

The Honorable John Barrasso
307 Dirksen Senate Office Building
Washington, DC 20510

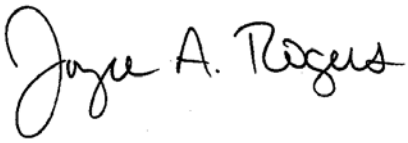
Dear Senator Wyden and Senator Barrasso:

AARP is pleased to endorse the bipartisan Seniors Mental Health Access Improvement Act (S. 562). Your legislation would provide for coverage of mental health counselor and marriage and family therapist services under Medicare Part B. Increasing access to mental health services is especially important as mental and behavioral health issues are becoming an increasing problem for older Americans – a problem that will only escalate further as the population ages.

Nearly one in five older adults in this country has one or more mental health or substance abuse conditions. This population is inadequately served by our health care system. AARP supports expanding the list of covered providers who can deliver these needed services and adequate reimbursement for mental health and substance abuse services. S. 562 will improve older Americans' access to licensed mental health professionals.

AARP appreciates your bipartisan leadership to help improve mental health services for seniors. We look forward to working with you on this and other issues important to older Americans. If you have any questions, please feel free to contact me, or have your staff contact Ariel Gonzalez on our Government Affairs staff at (202) 434-3770 or at agonzalez@aarp.org.

Sincerely,



Joyce A. Rogers
Senior Vice President
Government Affairs

Table 93. Mental health and substance abuse treatment providers, by discipline and state: number, United States, 2008, 2009, and 2011

[Data are based on association membership and certification data]

| State | Child and adolescent psychiatrists, 2009[1] | Psychiatrists, 2009[1] | Psychologists, 2011[2] | Clinical social workers, 2011[2] | Psychiatric nurses, 2008[3] | Substance abuse counselors, 2011[2] | Counselors, 2011[2,4] | Marriage and family therapists, 2011[2] |
|---|---|---|---|---|---|---|---|---|
| **United States** | **6,398** | **33,727** | **95,545** | **193,038** | **13,701** | **48,080** | **144,567** | **62,316** |
| Alabama | 65 | 306 | 440 | 1,390 | 24 | 31 | 1,624 | 65 |
| Alaska | 10 | 73 | 207 | 561 | 36 | 21 | 538 | 87 |
| Arizona | 104 | 512 | 2,010 | 1,487 | 112 | 669 | 2,405 | 974 |
| Arkansas | 35 | 198 | 503 | 1235 | 149 | 549 | 1,447 | 118 |
| California | 770 | 4,874 | 12,325 | 16,484 | 1,583 | 2,396 | 4,426 | 38,010 |
| Colorado | 146 | 542 | 2,178 | 3,770 | 211 | 2,944 | 7,834 | 574 |
| Connecticut | 147 | 702 | 1,655 | 4,809 | 348 | 929 | 1,804 | 974 |
| Delaware | 20 | 84 | 557 | 664 | 59 | 323 | 524 | 137 |
| District of Columbia | 46 | 237 | 523 | 1,232 | 20 | 376 | 540 | 68 |
| Florida | 255 | 1,603 | 4,145 | 8,956 | 1,596 | 61 | 10,340 | 2,069 |
| Georgia | 129 | 791 | 1,966 | 2,795 | 163 | 76 | 4,055 | 675 |
| Hawaii | 59 | 206 | 430 | 399 | 135 | 67 | 471 | 243 |
| Idaho | 20 | 80 | 169 | 1,587 | 129 | 66 | 949 | 213 |
| Illinois | 210 | 1,275 | 4,102 | 9,715 | 177 | 3,842 | 8,362 | 233 |
| Indiana | 83 | 396 | 1,002 | 4,344 | 126 | 200 | 1,752 | 839 |
| Iowa | 38 | 199 | 485 | 1,521 | 211 | 51 | 773 | 149 |
| Kansas | 60 | 237 | 1,312 | 1,822 | 60 | 87 | 1,072 | 575 |
| Kentucky | 68 | 321 | 1,078 | 1,445 | 432 | 591 | 1,457 | 499 |
| Louisiana | 54 | 360 | 424 | 2,858 | 195 | 78 | 2,380 | 631 |
| Maine | 48 | 206 | 405 | 2,479 | 257 | 716 | 1,048 | 81 |
| Maryland | 238 | 1,069 | 2,287 | 6,285 | 211 | 2,455 | 3,002 | 271 |
| Massachusetts | 300 | 1,628 | 5,007 | 11,401 | 496 | 169 | 5,783 | 622 |
| Michigan | 178 | 941 | 4,401 | 11,666 | 440 | 95 | 5,061 | 538 |
| Minnesota | 96 | 487 | 3,252 | 4,280 | 457 | 1,906 | 1,203 | 1,412 |
| Mississippi | 31 | 176 | 235 | 883 | 204 | 326 | 990 | 284 |

*(continued)*

Table 93. Mental health and substance abuse treatment providers, by discipline and state: number, United States, 2008, 2009, and 2011 *(continued)*

| State | Child and adolescent psychiatrists, 2009[1] | Psychiatrists, 2009[1] | Psychologists, 2011[2] | Clinical social workers, 2011[2] | Psychiatric nurses, 2008[3] | Substance abuse counselors, 2011[2] | Counselors, 2011[2,4] | Marriage and family therapists, 2011[2] |
|---|---|---|---|---|---|---|---|---|
| Missouri | 92 | 513 | 1,555 | 4,099 | 65 | 28 | 3,570 | 170 |
| Montana | 18 | 78 | 136 | 220 | 0 | 448 | 611 | 38 |
| Nebraska | 32 | 135 | 400 | 911 | 163 | 818 | 3,240 | 87 |
| Nevada | 26 | 161 | 430 | 853 | 82 | 1,147 | 602 | 439 |
| New Hampshire | 29 | 142 | 553 | 561 | 227 | 286 | 804 | 104 |
| New Jersey | 228 | 1,196 | 3,070 | 8,848 | 226 | 1,498 | 2,875 | 504 |
| New Mexico | 44 | 226 | 908 | 2,034 | 101 | 952 | 4,168 | 322 |
| New York | 730 | 4,177 | 10,102 | 29,676 | 558 | 1,990 | 6,434 | 637 |
| North Carolina | 191 | 922 | 2,238 | 3,986 | 150 | 2,040 | 2,212 | 585 |
| North Dakota | 19 | 68 | 173 | 456 | 81 | 305 | 309 | 34 |
| Ohio | 219 | 997 | 3,116 | 7,060 | 739 | 4,044 | 7,125 | 65 |
| Oklahoma | 38 | 269 | 381 | 1,242 | 0 | 1,780 | 4,008 | 394 |
| Oregon | 80 | 424 | 884 | 2,125 | 136 | 393 | 2,607 | 527 |
| Pennsylvania | 307 | 1,652 | 5,337 | 4,755 | 1,295 | 251 | 4,554 | 439 |
| Rhode Island | 35 | 186 | 573 | 1,721 | 131 | 80 | 296 | 423 |
| South Carolina | 111 | 381 | 457 | 1,241 | 84 | 726 | 2,100 | 222 |
| South Dakota | 16 | 57 | 129 | 330 | 13 | 16 | 404 | 596 |
| Tennessee | 86 | 507 | 1,766 | 2,097 | 572 | 423 | 1,788 | 422 |
| Texas | 393 | 1,584 | 6,260 | 3,824 | 536 | 6,051 | 14,703 | 2,896 |
| Utah | 44 | 183 | 572 | 2,097 | 0 | 398 | 1,061 | 472 |
| Vermont | 23 | 133 | 356 | 935 | 13 | 70 | 417 | 164 |
| Virginia | 178 | 876 | 1,575 | 3,705 | 59 | 1,516 | 2,751 | 862 |
| Washington | 108 | 670 | 2,085 | 3,187 | 429 | 2,758 | 5,179 | 1,264 |
| West Virginia | 18 | 138 | 480 | 648 | 85 | 32 | 948 | 16 |
| Wisconsin | 118 | 503 | 847 | 1,976 | 104 | 915 | 1,381 | 237 |
| Wyoming | 5 | 46 | 64 | 383 | 20 | 91 | 580 | 56 |

See notes on page 194.

CHCS CENTER FOR HEALTH CARE STRATEGIES, INC.

FACES OF MEDICAID
*DATA BRIEF*

# Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations

*By Cynthia Boyd, Bruce Leff, Carlos Weiss, Jennifer Wolff, Allison Hamblin, and Lorie Martin* *DECEMBER 2010*

ALTHOUGH MEDICAID FINANCES VITAL HEALTH SERVICES FOR MORE THAN 60 MILLION AMERICANS, PROGRAM COSTS ARE HIGHLY CONCENTRATED. NEARLY 60 PERCENT OF MEDICAID SPENDING IS INCURRED BY JUST FIVE PERCENT OF THE PROGRAM'S BENEFICIARIES,[1] INCLUDING MANY WITH DISABILITIES AND MULTIPLE CHRONIC HEALTH NEEDS. IN AN EARLIER *Faces of Medicaid* ANALYSIS PUBLISHED BY THE CENTER FOR HEALTH CARE STRATEGIES (CHCS), ROUGHLY 60 PERCENT OF MEDICAID'S HIGHEST-COST BENEFICIARIES WITH DISABILITIES WERE FOUND TO HAVE CO-OCCURRING PHYSICAL AND BEHAVIORAL HEALTH CONDITIONS.[2] IDENTIFYING SPECIFIC CLINICAL OPPORTUNITIES FOR MEDICAID BENEFICIARIES WITH MULTIMORBIDITY, PARTICULARLY THOSE WITH BEHAVIORAL HEALTH CONDITIONS, IS CRITICAL FOR GUIDING STATE EFFORTS TO IMPROVE QUALITY AND CONTROL SPENDING.

CHCS COMMISSIONED THIS LATEST *Faces of Medicaid* ANALYSIS BY JOHNS HOPKINS UNIVERSITY RESEARCHERS IN ORDER TO EXAMINE MULTIMORBIDITY PATTERNS AMONG ADULT MEDICAID BENEFICIARIES WITH DISABILITIES AND THE IMPLICATIONS OF SPECIFIC PATTERNS ON HOSPITALIZATION AND COST.[3] FOR THE ANALYSIS, "MULTIMORBIDITY PATTERN" WAS DEFINED AS THE SPECIFIC AND OFTEN MULTIPLE CONDITIONS THAT A PERSON HAS, E.G., A PERSON WITH DEPRESSION, HYPERTENSION, CHRONIC PAIN, AND ASTHMA, AS OPPOSED TO A SIMPLE TALLY OF THE NUMBER OF CONDITIONS THAT SOMEONE HAS, E.G., A PERSON WITH FIVE CHRONIC CONDITIONS. WHEREAS PREVIOUS ANALYSES OF MULTIMORBIDITY IN THIS SERIES RELIED ON THE BROAD DIAGNOSTIC CATEGORIES USED IN THE CHRONIC ILLNESS AND DISABILITY PAYMENT SYSTEM (CDPS),[4] THIS REPORT DRILLS DOWN TO THE DIAGNOSTIC LEVEL TO ALLOW FOR GREATER CLINICAL SPECIFICITY FOCUSING ON 13 IDENTIFIED INDEX CONDITIONS.[5] AND, THROUGH A COMPANION LITERATURE REVIEW, IT PROVIDES ACTIONABLE INFORMATION TO HELP MEDICAID STAKEHOLDERS DESIGN TARGETED STRATEGIES FOR HIGH-PRIORITY PATTERNS OF MULTIMORBIDITY.

THE ANALYSIS CONFIRMS THE OVERWHELMING PERVASIVENESS OF PHYSICAL AND BEHAVIORAL HEALTH COMORBIDITY AMONG MEDICAID'S HIGHEST-COST BENEFICIARIES. REINFORCING EARLIER *Faces* ANALYSES, THE FINDINGS DEMONSTRATE THAT MOST BENEFICIARIES WITH THE HIGHEST HOSPITALIZATION RATES AND COSTS HAVE NOT ONE CONDITION, BUT MANY. MENTAL ILLNESS IS NEARLY UNIVERSAL AMONG THE HIGHEST-COST, MOST FREQUENTLY HOSPITALIZED BENEFICIARIES, AND SIMILARLY, THE PRESENCE OF MENTAL ILLNESS AND/OR DRUG AND ALCOHOL DISORDERS IS ASSOCIATED WITH SUBSTANTIALLY HIGHER PER CAPITA COSTS AND HOSPITALIZATION RATES. THE FINDINGS CONFIRM THE NEED FOR PROGRAMS THAT INTEGRATE PHYSICAL AND BEHAVIORAL HEALTH CARE POLICIES, PROGRAMS, AND SERVICE DELIVERY.

## In Brief

*Identifying Medicaid's highest-need, highest-cost beneficiaries who are most likely to benefit from care management is an ongoing conundrum for states. Previous Faces of Medicaid analyses from the Center for Health Care Strategies (CHCS) documented the high prevalence of comorbidity among Medicaid beneficiaries with disabilities. This new analysis by researchers at Johns Hopkins University provides an even clearer picture. The findings identify:*

- *High-priority patterns of multimorbidity based on hospitalization rates and costs;*
- *The impact of mental illness and substance abuse on per capita costs and hospitalization rates; and*
- *Significant opportunities for clinical interventions, including a companion online literature review that inventories promising care models for high-priority multimorbidity patterns.*

*The brief also outlines how states can apply provisions within the Patient Protection and Affordable Care Act (ACA) to develop more integrated models for beneficiaries with serious mental illness, chronic physical conditions, and substance disorders.*

*Made possible through support from Kaiser Permanente.*

## STUDY DESIGN

CHCS partnered with researchers at Johns Hopkins University to conduct this analysis. The study used 2001 and 2002 data from the Medicaid Analytic Extract (MAX) files; both years of data were used to determine morbidity profiles, whereas service use and expenditures were analyzed for 2002 only. The results presented in this brief focus on adults with disabilities under age 65 who are not eligible for Medicare. Individuals enrolled in managed care plans were excluded as were costs associated with long-term supports and services. Although the initial analysis also examined Medicaid expenditures and service use for the dual eligible population, these data are not reported here because without Medicare data, the portrait for duals would be incomplete. The analysis examined disease prevalence, health care costs, and utilization for a total of 5.2 million Medicaid beneficiaries. This data brief summarizes findings for a subset totaling approximately 1.9 million non-dual adults with disabilities under age 65.

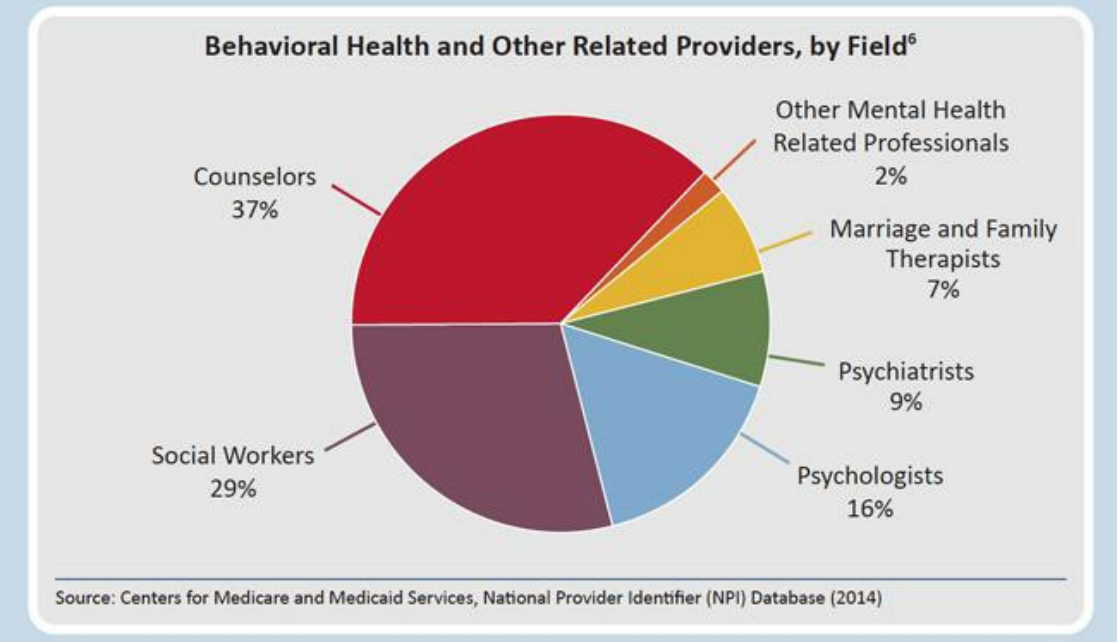
For this analysis, a "condition" was defined as a clinical entity that could be managed in a relatively homogenous manner. Prevalence of chronic conditions was determined based on the building blocks of the CDPS diagnostic classification framework as well as data from pharmacy and durable medical equipment claims. To identify high-priority multimorbidity patterns for targeting by Medicaid agencies and plans, the analysis identified 13 index conditions based on prevalence, potential for modification of clinical course, and costs of management. The 13 index conditions are: (1) asthma and/or chronic obstructive pulmonary disease (COPD); (2) cerebrovascular accident (stroke); (3) chronic pain; (4) congestive heart failure; (5) coronary heart disease; (6) dementia; (7) depressive disorders; (8) developmental disorders; (9) diabetes; (10) drug and alcohol disorders; (11) hypertension; (12) chronic renal failure or end stage renal disease; and (13) schizophrenia. To determine the set of associated conditions that could be considered in the pattern analysis for each index condition, the researchers identified the most common 15 from among 32 co-occurring clinical conditions. The researchers also considered five additional conditions based on either high per capita costs or the opportunities these conditions presented for the development of care management strategies that address distinct patterns of multimorbidity. There was a final narrowing of chronic conditions for the pattern analyses based jointly on prevalence and cost. Pattern analyses were used to identify prevalence of combinations of these conditions, associated costs and utilization patterns. For a full description of the study methodology, see the full report and appendices at www.chcs.org.

# What proportion of the nation's behavioral health providers are psychologists?

News from APA's Center for Workforce Studies.
September 2014, Vol 45, No. 8
Print version: page 18

As a way to create uniformity in reimbursement for health-care services, the Centers for Medicare and Medicaid Services groups different types of providers.[1,2] Through its National Provider Identifier system, all health-care providers self-identify their professional field into one of various broad categories[3], including behavioral and social science providers, which are the following: psychologist, psychiatrist[4], counselor, social worker, marriage and family therapist, and other behavioral health related fields.[1,2]

**As of May 2014, about 510,000 identified themselves as behavioral and social science providers. About 16 percent of them were psychologists.[1,5,6]**




Approximately 78 percent of licensed psychologists are registered in the NPI database.[1,6,7] Registration for an NPI is not a requirement to provide services. Providers who do not receive reimbursement from CMS or other forms of insurance do not need an NPI.

**— Auntré Hamp, MEd, MPH, Karen Stamm, PhD, Peggy Christidis, PhD, and Andrew Nigrinis, PhD**

*For more information, contact APA's Center for Workforce Studies.*

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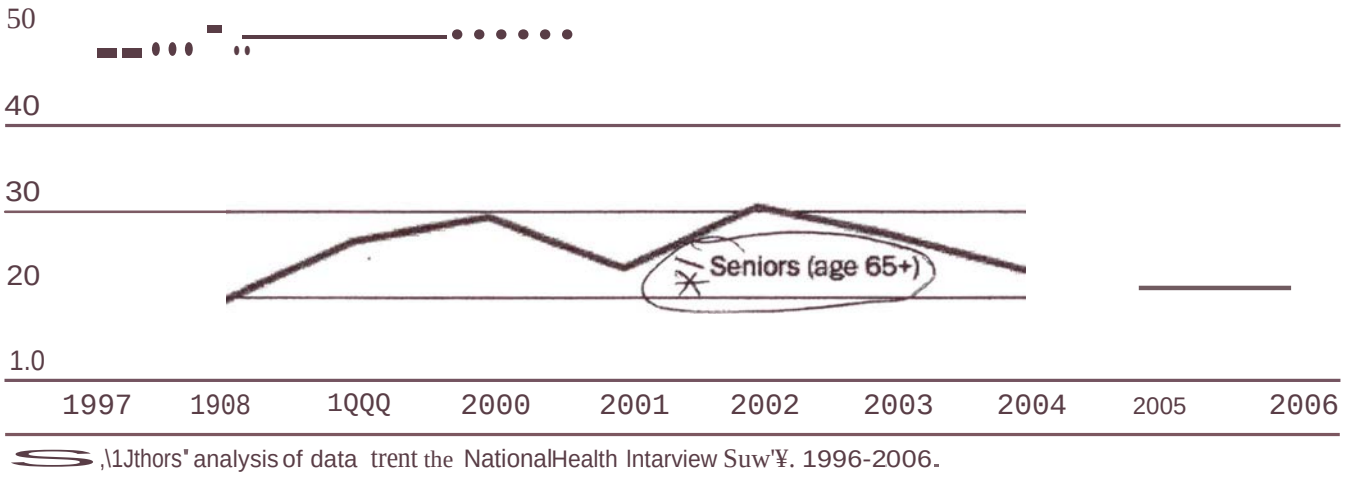
1. Centers for Medicare and Medicaid Services. (2014) National Provider Index Database [Data file accessed on 6/10/2014]. Retrieved from http://nppes.viva-it.com/NPI_Files.html
2. NPI's are currently required by most health insurances plans to qualify for reimbursement.
3. CMS utilizes the taxonomy code set maintained by the American National Standards Institute. The Health Care Provider Taxonomy Code Set can be found at: www.wpc-edi.com/reference/
4. For the purpose of this analysis, psychiatrists are counted in the behavioral health category.
5. The totals reported here underestimate the total number of professionals who provide health-related services. Those who are registered in the NPI database are eligible for reimbursement; the data reported here do not reflect the number of hours or amounts billed.
6. Data for this analysis include only individual providers and not organizational entities.
7. American Psychological Association (2014). 2012 APA state licensing board list. [Unpublished special analysis]. Washington, D.C.

EXHIBIT3

Rates Of Contact With A MentalHealth Professional For Those With A Mentat Health-Related Activity Limitation1997-2006




,\1Jthors" analysis of data trent the NationalHealth Intarview Suw'¥. 1996-2006.

## RELATED EVIDENCE

- Limited progress in psychosocial treatment access and quality

Medicare Access Coalition

NBCC • AAMFT • ACA • AMHCA • CAMFT • NCCBH • ABHW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114TH CONGRESS
2D SESSION

# S. 3435

To amend title XVIII of the Social Security Act to protect and preserve access of Medicare beneficiaries in rural areas to health care providers under the Medicare program, and for other purposes.

---

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 28, 2016

Mr. ROBERTS (for himself, Mr. FRANKEN, Mr. BARRASSO, and Ms. HEITKAMP) introduced the following bill; which was read twice and referred to the Committee on Finance

---

# A BILL

To amend title XVIII of the Social Security Act to protect and preserve access of Medicare beneficiaries in rural areas to health care providers under the Medicare program, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the "Craig Thomas Rural Hospital and Provider Equity Act of 2016".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

c. 6. Extension of the Medicare-dependent hospital (MDH) program.

c. 7. Reinstatement of Medicare wage index reclassifications for certain hospitals.

c. 8. Extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.

c. 9. Elimination of isolation test for cost-based ambulance reimbursement for critical access hospitals.

c. 10. Capital infrastructure revolving loan program.

c. 11. Extension of Medicare incentive payment program for physician scarcity areas.

c. 12. Extension of floor on Medicare work geographic adjustment.

c. 13. Recognition of attending physician assistants as attending physicians to serve hospice patients.

c. 14. Improving care planning for Medicare home health services.

c. 15. Rural health clinic improvements.

c. 16. Temporary Medicare payment increase for home health services furnished in a rural area.

c. 17. Extension of increased Medicare payments for rural ground ambulance services.

c. 18. Coverage of marriage and family therapist services and mental health counselor services under Part B of the Medicare program.

c. 19. Facilitating the provision of telehealth services across State lines.

c. 20. Medicare part A payment for anesthesiologist services in certain rural hospitals based on CRNA pass-through rules.

c. 21. Temporary floor on the practice expense geographic index for services furnished in rural areas outside of frontier States under the Medicare physician fee schedule.

c. 22. Revisions to standard for designation of sole community hospitals.

c. 23. Medicare treatment of standby and on-call time for CRNA services.

c. 24. State offices of rural health.

c. 25. Removing Medicare 96-hour physician certification requirement for inpatient critical access hospital services.

c. 26. Extension of enforcement instruction on supervision requirements for outpatient therapeutic services in critical access and small rural hospitals through 2017.

c. 27. Medicare payment for certain rural health clinic and Federally qualified health center services furnished to hospice patients.

**SEC. 2. SENSE OF THE SENATE.**

It is the sense of the Senate that—

(1) residents of rural and frontier communities should have access to affordable, quality health care;

(2) rural and frontier communities face unique challenges in health care delivery and financing;

(3) Federal health policy must reflect the unique needs of residents of rural and frontier communities and such communities in an equitable and sustainable manner; and

(4) stakeholders should work collectively to identify innovative policies that address the availability, delivery, and affordability of health care services in rural and frontier communities.

**SEC. 3. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.**

Section 1886(d)(5)(F)(xiv)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(xiv)(II)) is amended by adding at the end the following new sentence: "The preceding sentence shall not apply to any hospital with respect to discharges occurring on or after October 1, 2016, and before October 1, 2017.".

**SEC. 4. REINSTATEMENT AND EXPANSION OF THE MEDICARE HOLD HARMLESS PROVISION UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT (HOPD) SERVICES FOR CERTAIN HOSPITALS.**

Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by inserting "and for such services furnished on or after January 1, 2016, and before January 1, 2017," after "covered OPD services furnished on or after January 1, 2006, and before January 1, 2013,"; and

(B) in the second sentence—

(i) by striking "and 85" and inserting "85"; and

(ii) by inserting the following before the period at the end: ", and 100 percent with respect to such services furnished on or after January 1, 2016, and before January 1, 2017"; and

(2) in subclause (III)—

(A) in the first sentence—

(i) by inserting "and for such services furnished on or after January 1, 2016, and before January 1, 2017," after "covered OPD services furnished on or after January 1, 2009, and before January 1, 2013,"; and

(ii) by striking "85 percent" and inserting "the applicable percentage (as determined under the second sentence of subclause (II) for the year)"; and

(B) in the second sentence, by inserting "and in the case of such services furnished on or after January 1, 2016, and before January 1, 2017," after "covered OPD services furnished on or after January 1, 2010, and before March 1, 2012,".

**SEC. 5. EXTENSION AND TEMPORARY IMPROVEMENTS TO THE MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.**

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (B), in the matter preceding clause (i), by striking "fiscal year 2018" and inserting "fiscal year 2019";

(2) in subparagraph (C)(i), by striking "fiscal years 2011 through 2017, 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A" and inserting "fiscal years 2011 through 2016, 1,600 discharges of individuals entitled to, or enrolled for, benefits under part A, or, with respect to fiscal years 2017 and 2018, 2,000 discharges of such individuals"; and

(3) in subparagraph (D)—

(A) by striking "1,600" and inserting "the applicable number of"; and

(B) by adding at the end the following new sentence: "For purposes of the preceding sentence, the term 'applicable number of discharges' means 1,600 discharges with respect to discharges occurring in fiscal years 2011 through 2016, and 2,000 discharges with respect to discharges occurring in fiscal years 2017 and 2018.".

**SEC. 6. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.**

(a) IN GENERAL.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking "October 1, 2017" and inserting "October 1, 2018"; and

(2) in clause (ii)(II), by striking "October 1, 2017" and inserting "October 1, 2018".

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking "October 1, 2017" and inserting "October 1, 2018"; and

(B) in clause (iv), by striking "through fiscal year 2017" and inserting "through fiscal year 2018".

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking "through fiscal year 2017" and inserting "through fiscal year 2018".

**SEC. 7. REINSTATEMENT OF MEDICARE WAGE INDEX RECLASSIFICATIONS FOR CERTAIN HOSPITALS.**

(a) REINSTATEMENT OF CORRECTION OF MID-YEAR RECLASSIFICATION EXPIRATION FOR CERTAIN HOSPITALS.—

(1) IN GENERAL.—The first sentence of subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395ww note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173), section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275), sections 3137(a) and 10317 of the Patient Protection and Affordable Care Act (Public Law 111-148), section 102 of the Medicare and Medicaid Extenders Act of 2010 (Public Law 111-309), section 302(a) of the Temporary Payroll Tax Cut Continuation Act of 2011 (Public Law 112-78), and section 3001(a) of the Middle Class Tax Relief and Job Creation Act of 2012 (Public Law 112-96), is amended by inserting "and, in the case of a hospital described in section 7(a)(2) of the Craig Thomas Rural Hospital and Provider Equity Act of 2016, shall apply such reclassification of such hospital during the period beginning on January 1, 2016, and ending on December 31, 2016" before the period at the end.

(2) HOSPITAL DESCRIBED.—A hospital described in this paragraph is—

(A) a hospital—

(i) that is described in such subsection (a) such section 106; and

(ii)(I) that is located in a rural area; and

(II) for which the Secretary has determined the reinstatement under the provisions of, and amendments made by, this section is appropriate; or

(B) a sole community hospital located in a State with less than 10 people per square mile that was provided with a special exception reclassification extension under section 117(a)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

(b) NOT BUDGET NEUTRAL.—The provisions of, and amendments made by, this section shall not be effected in a budget-neutral manner.

**SEC. 8. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.**

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l note), section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395l note), section 3122 of the Patient Protection and Affordable Care Act (Public Law 111-148), and section 109 of the Medicare and Medicaid Extenders Act of 2010 (Public Law 111-309), is amended—

(1) by striking "or during the 2-year" and inserting ", during the 2-year"; and

(2) by inserting ", or during the 1-year period beginning on January 1, 2017" before the period at the end.

**SEC. 9. ELIMINATION OF ISOLATION TEST FOR COST-BASED AMBULANCE REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS.**

(a) IN GENERAL.—Section 1834(l)(8) of the Social Security Act (42 U.S.C. 1395m(l)(8)) is amended—

(1) in subparagraph (B)—

(A) by striking "owned and"; and

(B) by inserting "(including when such services are provided by the entity under an arrangement with the hospital)" after "hospital"; and

(2) by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2017.

**SEC. 10. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM.**

(a) IN GENERAL.—Part A of title XVI of the Public Health Service Act (42 U.S.C. 300q et seq.) is amended by adding at the end the following new section:

"CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

"SEC. 1603. (a) Authority To Make and Guarantee Loans.—

"(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

"(A) the acquisition of land necessary for the capital improvements;

"(B) the renovation or modernization of any building;

"(C) the acquisition or repair of fixed or major movable equipment; and

"(D) such other project expenses as the Secretary determines appropriate.

"(2) AUTHORITY TO GUARANTEE LOANS.—

"(A) IN GENERAL.—The Secretary may guarantee the payment of principal and interest for loans made to rural entities for projects for any capital improvement described in paragraph (1) to any non-Federal lender.

"(B) INTEREST SUBSIDIES.—In the case of a guarantee of any loan made to a rural entity under subparagraph (A), the Secretary may pay to the holder of such loan, for and on behalf of the project for which the loan was made, amounts sufficient to reduce (by not more than 3 percent) the net effective interest rate otherwise payable on such loan.

"(b) AMOUNT OF LOAN.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed $5,000,000.

"(c) FUNDING LIMITATIONS.—

"(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Federal Credit Reform Act of 1990 scoring protocol with respect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed $50,000,000 per year.

"(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed $250,000,000 per year.

"(d) CAPITAL ASSESSMENT AND PLANNING GRANTS.—

"(1) NONREPAYABLE GRANTS.—Subject to paragraph (2), the Secretary may make a grant to a rural entity, in an amount not to exceed $50,000, for purposes of capital assessment and business planning.

"(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed $2,500,000 per year.

"(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after January 1, 2017.".

(b) RURAL ENTITY DEFINED.—Section 1624 of the Public Health Service Act (42 U.S.C. 300s-3) is amended by adding at the end the following new paragraph:

"(15)(A) The term 'rural entity' includes—

"(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

"(ii) any medical facility with at least 1 bed, but with less than 50 beds, that is located in—

"(I) a county that is not part of a metropolitan statistical area; or

"(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

"(iii) a hospital that is classified as a rural, regional, or national referral center under section 1886(d)(5)(C) of the Social Security Act; and

"(iv) a hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

"(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the Medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).".

(c) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q-2) is amended—

(1) in subsection (b)(2)(D), by inserting "or 1603(a)(2)(B)" after "1601(a)(2)(B)"; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking "section 1601(a)(2)(B)" and inserting "sections 1601(a)(2)(B) and 1603(a)(2)(B)"; and

(B) in paragraph (2)(A), by inserting "or 1603(a)(2)(B)" after "1601(a)(2)(B)".

**SEC. 11. EXTENSION OF MEDICARE INCENTIVE PAYMENT PROGRAM FOR PHYSICIAN SCARCITY AREAS.**

Section 1833(u)(1) of the Social Security Act (42 U.S.C. 1395l(u)(1)) is amended by inserting ", and such services furnished on or after April 1, 2016, and before April 1, 2017" after "2008".

**SEC. 12. EXTENSION OF FLOOR ON MEDICARE WORK GEOGRAPHIC ADJUSTMENT.**

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(E)) is amended by striking "January 1, 2018" and inserting "January 1, 2019".

**SEC. 13. RECOGNITION OF ATTENDING PHYSICIAN ASSISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.**

(a) IN GENERAL.—Section 1861(dd)(3)(B) of the Social Security Act (42 U.S.C. 1395x(dd)(3)(B)) is amended—

(1) by striking "or nurse practitioner" and inserting ", the nurse practitioner"; and

(2) by inserting ", or the physician assistant (as defined in such subsection)" after "subsection (aa)(5))".

(b) PERMITTING PHYSICIAN ASSISTANTS WHEN DELEGATED BY A PHYSICIAN TO ORDER HOSPICE CARE.—Section 1814(a)(7)(A) of the Social Security Act (42 U.S.C. 1395f(a)(7)(A)) is amended—

(1) in clause (i)(I), by striking "does not include a nurse practitioner" and inserting "only includes a physician assistant if a physician has delegated the authority to make the certification required under this paragraph to such physician assistant"; and

(2) by amending clause (ii) to read as follows:

"(ii) in a subsequent 90- or 60-day period—

"(I) the medical director or physician described in clause (i)(II);

"(II) a physician employed by the hospice program providing (or arranging for) the care or providing care to the individual under arrangement with such hospice program;

"(III) a nurse practitioner employed by such hospice program or providing care to the individual under arrangement with such hospice program; or

"(IV) a physician assistant employed by such hospice program or providing care to the individual under arrangement with such hospice program, provided that an individual described in subclause (I) or (II) has delegated the authority to make the recertification required under this clause to such physician assistant,

recertifies at the beginning of the period that the individual is terminally ill based on such clinical judgment;".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2017.

**SEC. 14. IMPROVING CARE PLANNING FOR MEDICARE HOME HEALTH SERVICES.**

(a) PART A PROVISIONS.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended—

(1) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting ", a nurse practitioner or clinical nurse specialist who is working in collaboration with a physician in accordance with State law, a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of a physician" after "1866(j)"; and

(B) in subparagraph (C)—

(i) by inserting ", a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant (as the case may be)" after "physician" the first 2 times it appears; and

(ii) by striking ", and, in the case of a certification made by a physician" and all that follows through "face-to-face encounter" and inserting ", and, in the case of a certification made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant (as the case may be) after January 1, 2017, prior to making such certification the physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant must document that the physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant has had a face-to-face encounter"; and

(2) in the flush matter following paragraph (8)—

(A) in the first sentence, by inserting "certified nurse-midwife," after "clinical nurse specialist,";

(B) in the second sentence—

(i) by striking "physician certification" and inserting "certification";

(ii) by inserting "(or on January 1, 2017, in the case of regulations to implement the amendments made by section 14 of the Craig Thomas Rural Hospital and Provider Equity Act of 2016)" after "1981"; and

(iii) by striking "a physician who" and inserting "a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant who"; and

(C) in the third sentence, by inserting ", nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant" after "physician".

(b) PART B PROVISIONS.—Section 1835(a) of the Social Security Act (42 U.S.C. 1395n(a)) is amended—

(1) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting ", a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)) who is working in collaboration with a physician in accordance with State law, a certified nurse-midwife (as defined in section 1861(gg)) as authorized by State law, or a physician assistant (as defined in section 1861(aa)(5)) under the supervision of a physician" after "1866(j)"; and

(B) in subparagraph (A)—

(i) in each of clauses (ii) and (iii) of subparagraph (A), by inserting ", a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant (as the case may be)" after "physician"; and

(ii) in clause (iv), by striking "after January 1, 2010" and all that follows through "face-to-face encounter" and inserting "made by a physician after January 1, 2010, or by a nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant (as the case may be) after January 1, 2017, prior to making such certification the physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant must document that the physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant has had a face-to-face encounter";

(2) in the third sentence, by inserting ", nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant (as the case may be)" after "physician";

(3) in the fourth sentence—

(A) by striking "physician certification" and inserting "certification";

(B) by inserting "(or on January 1, 2017, in the case of regulations to implement the amendments made by section 14 of the Craig Thomas Rural Hospital and Provider Equity Act of 2016)" after "1981"; and

(C) by striking "a physician who" and inserting "a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant who"; and

(4) in the fifth sentence, by inserting ", nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant" after "physician".

(c) DEFINITION PROVISIONS.—

(1) HOME HEALTH SERVICES.—Section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) is amended—

(A) in the matter preceding paragraph (1)—

(i) by inserting ", a nurse practitioner or a clinical nurse specialist (as those terms are defined in subsection (aa)(5)), a certified nurse-midwife (as defined in section 1861(gg)), or a physician assistant (as defined in subsection (aa)(5))" after "physician" the first place it appears; and

(ii) by inserting ", a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant" after "physician" the second place it appears; and

(B) in paragraph (3), by inserting ", a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant" after "physician".

(2) HOME HEALTH AGENCY.—Section 1861(o)(2) of the Social Security Act (42 U.S.C. 1395x(o)(2)) is amended—

(A) by inserting ", nurse practitioners or clinical nurse specialists (as those terms are defined in subsection (aa)(5)), certified nurse-midwives (as defined in section 1861(gg)), or physician assistants (as defined in subsection (aa)(5))" after "physicians"; and

(B) by inserting ", nurse practitioner, clinical nurse specialist, certified nurse-midwife, physician assistant," after "physician".

(d) HOME HEALTH PROSPECTIVE PAYMENT SYSTEM PROVISIONS.—Section 1895 of the Social Security Act (42 U.S.C. 1395fff) is amended—

(1) in subsection (c)(1), by inserting ", the nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)), the certified nurse-midwife (as defined in section 1861(gg)), or the physician assistant (as defined in section 1861(aa)(5))," after "physician"; and

(2) in subsection (e)—

(A) in paragraph (1)(A), by inserting ", a nurse practitioner or clinical nurse specialist (as those terms are defined in section 1861(aa)(5)), a certified nurse-midwife (as defined in section 1861(gg)), or a physician assistant (as defined in section 1861(aa)(5))" after "physician"; and

(B) in paragraph (2)—

(i) in the heading, by striking "**Physician certification**" and inserting "**Rule of construction regarding requirement for certification**"; and

(ii) by striking "physician".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2017.

**SEC. 15. RURAL HEALTH CLINIC IMPROVEMENTS.**

Section 1833(f) of the Social Security Act (42 U.S.C. 1395l(f)) is amended—

(1) in paragraph (1), by striking ", and" at the end and inserting a semicolon;

(2) in paragraph (2)—

(A) by inserting "(before 2017)" after "in a subsequent year"; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new paragraphs:

"(3) in 2017, at $110 per visit; and

"(4) for years following 2017, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as so defined) applicable to primary care services (as so defined) furnished as of the first day of that year.".

**SEC. 16. TEMPORARY MEDICARE PAYMENT INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.**

Section 421(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2283), as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Public Law 109-171; 120 Stat. 46), section 3131(c) of the Patient Protection and Affordable Care Act (Public Law 111-148; 124 Stat. 428), and section 210 of the Medicare Access and CHIP Reauthorization Act of 2015 (Public Law 114-10; 129 Stat. 151), is amended by striking "January 1, 2018" and inserting "January 1, 2019" each place it appears.

**SEC. 17. EXTENSION OF INCREASED MEDICARE PAYMENTS FOR RURAL GROUND AMBULANCE SERVICES.**

(a) IN GENERAL.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—

(1) in the matter preceding clause (i), by striking "July 1, 2004" and all that follows through "originates in";

(2) in clause (i)—

(A) by inserting "July 1, 2004, and before January 1, 2007, and for such services furnished on or after July 1, 2008, and before January 1, 2019, for which the transportation originates in" before "a rural"; and

(B) by striking "2018" and inserting "2017, or 5 percent if such service is furnished on or after January 1, 2017, and before January 1, 2019"; and

(3) in clause (ii), by inserting "July 1, 2004, and before January 1, 2007, and for such services furnished on or after July 1, 2008, and before January 1, 2018, for which the transportation originates in" before "an area not".

(b) SUPER RURAL AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended by striking "January 1, 2018" and inserting "January 1, 2019".

**SEC. 18. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM**.

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (EE), by striking "and" after the semicolon at the end;

(B) in subparagraph (FF), by inserting "and" after the semicolon at the end; and

(C) by adding at the end the following new subparagraph:

"(GG) marriage and family therapist services (as defined in subsection (iii)(1)) and mental health counselor services (as defined in subsection (iii)(3));".

(2) DEFINITIONS.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"(iii) MARRIAGE AND FAMILY THERAPIST SERVICES; MARRIAGE AND FAMILY THERAPIST; MENTAL HEALTH COUNSELOR SERVICES; MENTAL HEALTH COUNSELOR.—(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

"(2) The term 'marriage and family therapist' means an individual who—

"(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

"(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

"(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

"(3) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

"(4) The term 'mental health counselor' means an individual who—

"(A) possesses a master's or doctor's degree in mental health counseling or a related field;

"(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

"(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.".

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

"(v) marriage and family therapist services (as defined in section 1861(iii)(1)) and mental health counselor services (as defined in section 1861(iii)(3));".

(4) AMOUNT OF PAYMENT.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and (AA)" and inserting "(AA)"; and

(B) by inserting before the semicolon at the end the following: ", and (BB) with respect to marriage and family therapist services and mental health counselor services under section 1861(s)(2)(GG), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L)".

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting "marriage and family therapist services (as defined in section 1861(iii)(1)), mental health counselor services (as defined in section 1861(iii)(3)),," after "qualified psychologist services,".

(6) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

"(vii) A marriage and family therapist (as defined in section 1861(iii)(2)).

"(viii) A mental health counselor (as defined in section 1861(iii)(4)).".

(b) COVERAGE OF CERTAIN MENTAL HEALTH SERVICES PROVIDED IN CERTAIN SETTINGS.—

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking "or by a clinical social worker (as defined in subsection (hh)(1))" and inserting ", by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (iii)(2)), or by a mental health counselor (as defined in subsection (iii)(4))".

(2) HOSPICE PROGRAMS.—Section 1861(dd)(2)(B)(i)(III) of the Social Security Act (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting ", marriage and family therapist, or mental health counselor" after "social worker".

(c) AUTHORIZATION OF MARRIAGE AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS TO DEVELOP DISCHARGE PLANS FOR POST-HOSPITAL SERVICES.—Section 1861(ee)(2)(G) of the Social Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting ", including a marriage and family therapist and a mental health counselor who meets qualification standards established by the Secretary" before the period at the end.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2017.

**SEC. 19. FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.**

(a) IN GENERAL.—For purposes of expediting the provision of telehealth services, for which payment is made under the Medicare program, across State lines, the Secretary of Health and Human Services shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of provisions allowing for multistate practitioner practice across State lines.

(b) DEFINITIONS.—In subsection (a):

(1) TELEHEALTH SERVICE.—The term "telehealth service" has the meaning given that term in subparagraph (F) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(2) PHYSICIAN, PRACTITIONER.—The terms "physician" and "practitioner" have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(3) MEDICARE PROGRAM.—The term "Medicare program" means the program of health insurance administered by the Secretary of Health and Human Services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

**SEC. 20. MEDICARE PART A PAYMENT FOR ANESTHESIOLOGIST SERVICES IN CERTAIN RURAL HOSPITALS BASED ON CRNA PASS-THROUGH RULES**.

(a) IN GENERAL.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended by adding at the end the following new subsection:

"(m) ANESTHESIOLOGIST SERVICES PROVIDED IN CERTAIN RURAL HOSPITALS.—(1) Notwithstanding any other provision of this title, coverage and payment shall be provided under this part for physicians' services that are anesthesia services furnished by a physician who is an anesthesiologist in a rural hospital described in paragraph (3) in the same manner as payment is made under the exception provided in section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989 (42 U.S.C. 1395k note) (relating to payment on a reasonable cost, pass-through basis), for certified registered nurse anesthetist services furnished by a certified registered nurse anesthetist in a hospital described in such section.

"(2) No payment shall be made under any other provision of this title for physicians' services for which payment is made under this subsection.

"(3) A rural hospital described in this paragraph is a hospital described in section 9320(k) of the Omnibus Budget Reconciliation Act of 1986, as so amended (42 U.S.C. 1395k note), except that—

"(A) any reference in such section to a 'certified registered nurse anesthetist' or 'anesthetist' is deemed a reference to a 'physician who is an anesthesiologist' or 'anesthesiologist', respectively; and

"(B) any reference to 'January 1, 1988' or '1987' is deemed a reference to such date and year as the Secretary shall specify.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished during cost reporting periods beginning on or after the date of the enactment of this Act.

**SEC. 21. TEMPORARY FLOOR ON THE PRACTICE EXPENSE GEOGRAPHIC INDEX FOR SERVICES FURNISHED IN RURAL AREAS OUTSIDE OF FRONTIER STATES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.**

Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)) is amended by adding at the end the following new subparagraph:

"(J) FLOOR AT 1.0 ON PRACTICE EXPENSE GEOGRAPHIC INDEX FOR SERVICES FURNISHED IN RURAL AREAS OUTSIDE OF FRONTIER STATES.—For purposes of payment for services furnished in a rural area (other than a rural area located in a State to which subparagraph (I) applies) on or after January 1, 2017, and before January 1, 2018, after calculating the practice expense index under subparagraph (A)(i), the Secretary shall increase any such index to 1.0 if such index would otherwise be less than 1.0. The preceding sentence shall not be applied in a budget neutral manner.".

"(J) FLOOR AT 1.0 ON PRACTICE EXPENSE GEOGRAPHIC INDEX FOR SERVICES FURNISHED IN RURAL AREAS OUTSIDE OF FRONTIER STATES.—For purposes of payment for services furnished in a rural area (other than a rural area located in a State to which subparagraph (I) applies) on or after January 1, 2017, and before January 1, 2018, after calculating the practice expense index under subparagraph (A)(i), the Secretary shall increase any such index to 1.0 if such index would otherwise be less than 1.0. The preceding sentence shall not be applied in a budget neutral manner.".

**SEC. 22. REVISIONS TO STANDARD FOR DESIGNATION OF SOLE COMMUNITY HOSPITALS.**

Section 1886(d)(5)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(D)(iv)) is amended by adding at the end the following new sentence: "Under such standard, the time required for an individual to travel to the nearest alternative source of care shall be measured over improved roads maintained by a local, State, or Federal Government entity for use by the general public which is the most expeditious and accessible route as designated by law enforcement for emergency vehicle travel.".

**SEC. 23. MEDICARE TREATMENT OF STANDBY AND ON-CALL TIME FOR CRNA SERVICES.**

(a) IN GENERAL.—Section 9320(k) of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. 1395k note), as added by section 608(c)(2) of the Family Support Act of 1988 and amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989, is amended by adding at the end the following:

"(3) In determining the reasonable costs incurred by a hospital or critical access hospital for the services of a certified registered nurse anesthetist under this subsection, the Secretary shall include standby costs and on-call costs incurred by the hospital or critical access hospital, respectively, with respect to such nurse anesthetist.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to costs incurred in cost reporting periods beginning in fiscal years after fiscal year 2007 and before fiscal year 2017.

**SEC. 24. STATE OFFICES OF RURAL HEALTH.**

Section 338J of the Public Health Service Act (42 U.S.C. 254r) is amended to read as follows:

**"SEC. 338J. GRANTS TO STATE OFFICES OF RURAL HEALTH.**

"(a) IN GENERAL.—The Secretary, acting through the Director of the Federal Office of Rural Health Policy (established under section 711 of the Social Security Act), shall make grants to each State Office of Rural Health for the purpose of improving health care in rural areas.

"(b) REQUIREMENT OF MATCHING FUNDS.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary may not make a grant under subsection (a) unless the State office of rural health involved agrees, with respect to the costs to be incurred in carrying out the purpose described in such subsection, to provide non-Federal contributions toward such costs in an amount equal to $3 for each $1 of Federal funds provided in the grant.

"(2) WAIVER OR REDUCTION.—The Secretary is authorized to waive or reduce the non-Federal contribution if the State office of rural health can demonstrate that requiring matching funds would limit its ability to carry out the purpose described in subsection (a).

"(3) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(c) CERTAIN REQUIRED ACTIVITIES.—Recipients of a grant under subsection (a) shall use the grant funds for purposes of—

"(1) maintaining within the State office of rural health a clearinghouse for collecting and disseminating information on—

"(A) rural health care issues;

"(B) research findings relating to rural health care; and

"(C) innovative approaches to the delivery of health care in rural areas;

"(2) coordinating the activities carried out in the State that relate to rural health care, including providing coordination for the purpose of avoiding redundancy in such activities; and

"(3) identifying Federal and State programs regarding rural health, and providing technical assistance to public and nonprofit private entities regarding participation in such programs.

"(d) REQUIREMENT REGARDING ANNUAL BUDGET FOR OFFICE.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that, for any fiscal year for which the State office of rural health receives such a grant, the office operated pursuant to subsection (a) of this section will be provided with an annual budget of not less than $150,000.

"(e) CERTAIN USES OF FUNDS.—

"(1) RESTRICTIONS.—The Secretary may not make a grant under subsection (a) unless the State office of rural health involved agrees that the grant will not be expended—

"(A) to provide health care (including providing cash payments regarding such care);

"(B) to conduct activities for which Federal funds are expended—

"(i) within the State to provide technical and other nonfinancial assistance under section 330A(f);

"(ii) under a memorandum of agreement entered into with the State office of rural health under section 330A(h); or

"(iii) under a grant under section 338I;

"(C) to purchase medical equipment, to purchase ambulances, aircraft, or other vehicles, or to purchase major communications equipment;

"(D) to purchase or improve real property; or

"(E) to carry out any activity regarding a certificate of need.

"(2) AUTHORITIES.—Activities for which a State office of rural health may expend a grant under subsection (a) include—

"(A) paying the costs of maintaining an office of rural health for purposes of subsection (a);

"(B) subject to paragraph (1)(B)(iii), paying the costs of any activity carried out with respect to recruiting and retaining health professionals to serve in rural areas of the State; and

"(C) providing grants and contracts to public and nonprofit private entities to carry out activities authorized in this section.

"(3) LIMIT ON INDIRECT COSTS.—The Secretary may impose a limit of no more than 15 percent on indirect costs claimed by the recipient of the grant.

"(f) REPORTS.—The Secretary may not make a grant under subsection (a) unless the State office of rural health involved agrees—

"(1) to submit to the Secretary reports or performance data containing such information as the Secretary may require regarding activities carried out under this section; and

"(2) to submit such a report or performance data not later than than September 30 of any fiscal year for which the State office of rural health has received such a grant.

"(g) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out such subsection.

"(h) NONCOMPLIANCE.—The Secretary may not make payments under subsection (a) to a State office of rural health for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the State office of rural health has complied with each of the agreements made by the State office of rural health under this section.

"(i) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—For the purpose of making grants under subsection (a), there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2017 through 2021.

"(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available until expended.".

**"SEC. 338J. GRANTS TO STATE OFFICES OF RURAL HEALTH.**

"(a) IN GENERAL.—The Secretary, acting through the Director of the Federal Office of Rural Health Policy (established under section 711 of the Social Security Act), shall make grants to each State Office of Rural Health for the purpose of improving health care in rural areas.

"(b) REQUIREMENT OF MATCHING FUNDS.—

"(1) IN GENERAL.—Subject to paragraph (2), the Secretary may not make a grant under subsection (a) unless the State office of rural health involved agrees, with respect to the costs to be incurred in carrying out the purpose described in such subsection, to provide non-Federal contributions toward such costs in an amount equal to $3 for each $1 of Federal funds provided in the grant.

"(2) WAIVER OR REDUCTION.—The Secretary is authorized to waive or reduce the non-Federal contribution if the State office of rural health can demonstrate that requiring matching funds would limit its ability to carry out the purpose described in subsection (a).

"(3) DETERMINATION OF AMOUNT OF NON-FEDERAL CONTRIBUTION.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

"(c) CERTAIN REQUIRED ACTIVITIES.—Recipients of a grant under subsection (a) shall use the grant funds for purposes of—

"(1) maintaining within the State office of rural health a clearinghouse for collecting and disseminating information on—

"(A) rural health care issues;

"(B) research findings relating to rural health care; and

"(C) innovative approaches to the delivery of health care in rural areas;

"(2) coordinating the activities carried out in the State that relate to rural health care, including providing coordination for the purpose of avoiding redundancy in such activities; and

"(3) identifying Federal and State programs regarding rural health, and providing technical assistance to public and nonprofit private entities regarding participation in such programs.

"(d) REQUIREMENT REGARDING ANNUAL BUDGET FOR OFFICE.—The Secretary may not make a grant under subsection (a) unless the State involved agrees that, for any fiscal year for which the State office of rural health receives such a grant, the office operated pursuant to subsection (a) of this section will be provided with an annual budget of not less than $150,000.

"(e) CERTAIN USES OF FUNDS.—

"(1) RESTRICTIONS.—The Secretary may not make a grant under subsection (a) unless the State office of rural health involved agrees that the grant will not be expended—

"(A) to provide health care (including providing cash payments regarding such care);

"(B) to conduct activities for which Federal funds are expended—

"(i) within the State to provide technical and other nonfinancial assistance under section 330A(f);

"(ii) under a memorandum of agreement entered into with the State office of rural health under section 330A(h); or

"(iii) under a grant under section 338I;

"(C) to purchase medical equipment, to purchase ambulances, aircraft, or other vehicles, or to purchase major communications equipment;

"(D) to purchase or improve real property; or

"(E) to carry out any activity regarding a certificate of need.

"(2) AUTHORITIES.—Activities for which a State office of rural health may expend a grant under subsection (a) include—

"(A) paying the costs of maintaining an office of rural health for purposes of subsection (a);

"(B) subject to paragraph (1)(B)(iii), paying the costs of any activity carried out with respect to recruiting and retaining health professionals to serve in rural areas of the State; and

"(C) providing grants and contracts to public and nonprofit private entities to carry out activities authorized in this section.

"(3) LIMIT ON INDIRECT COSTS.—The Secretary may impose a limit of no more than 15 percent on indirect costs claimed by the recipient of the grant.

"(f) REPORTS.—The Secretary may not make a grant under subsection (a) unless the State office of rural health involved agrees—

"(1) to submit to the Secretary reports or performance data containing such information as the Secretary may require regarding activities carried out under this section; and

"(2) to submit such a report or performance data not later than than September 30 of any fiscal year for which the State office of rural health has received such a grant.

"(g) REQUIREMENT OF APPLICATION.—The Secretary may not make a grant under subsection (a) unless an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out such subsection.

"(h) NONCOMPLIANCE.—The Secretary may not make payments under subsection (a) to a State office of rural health for any fiscal year subsequent to the first fiscal year of such payments unless the Secretary determines that, for the immediately preceding fiscal year, the State office of rural health has complied with each of the agreements made by the State office of rural health under this section.

"(i) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—For the purpose of making grants under subsection (a), there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2017 through 2021.

"(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available until expended.".

**SEC. 25. REMOVING MEDICARE 96-HOUR PHYSICIAN CERTIFICATION REQUIREMENT FOR INPATIENT CRITICAL ACCESS HOSPITAL SERVICES.**

(a) IN GENERAL.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)), is amended—

(1) in paragraph (6), by adding "and" at the end;

(2) in paragraph (7), at the end of subparagraph (E), by striking "; and" and inserting a period; and

(3) by striking paragraph (8).

(b) APPLICATION.—The amendments made by subsection (a) shall apply with respect to items and services furnished on or after January 1, 2017.

**SEC. 26. EXTENSION OF ENFORCEMENT INSTRUCTION ON SUPERVISION REQUIREMENTS FOR OUTPATIENT THERAPEUTIC SERVICES IN CRITICAL ACCESS AND SMALL RURAL HOSPITALS THROUGH 2017.**

Section 1 of Public Law 113-198, as amended by section 1 of Public Law 114-112, is amended—

(1) in the section heading, by striking "**and 2015**" and inserting "**, 2015, 2016, and 2017**"; and

(2) by striking "and 2015" and inserting ", 2015, 2016, and 2017".

**SEC. 27. MEDICARE PAYMENT FOR CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FURNISHED TO HOSPICE PATIENTS.**

(a) IN GENERAL.—Section 1812(d)(2) of the Social Security Act (42 U.S.C. 1395d(d)(2)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking "subparagraphs (B) and (C)" and inserting "the succeeding provisions of this paragraph";

(B) in clause (ii)(II), by striking the semicolon at the end and inserting a period; and

(C) by striking the flush matter following clause (ii)(II); and

(2) by adding at the end the following new subparagraph:

"(E) Subparagraph (A)(ii) shall not apply to—

"(i) physicians' services furnished by the individual's attending physician (as defined in section 1861(dd)(3)(B)), if not an employee of the hospice program;

"(ii) services provided by (or under arrangements made by) the hospice program; or

"(iii) rural health clinic services (as defined in paragraph (1) of section 1861(aa)) and Federally qualified health center services (as defined in paragraph (3) of such section) if such services—

"(I) would otherwise be physicians' services if furnished by an individual not affiliated with a rural health clinic (as defined in paragraph (2) of such section) or a Federally qualified health center (as defined in paragraph (4) of such section); and

"(II) are—

"(aa) furnished by the individual's attending physician (as so defined), if not an employee of the hospice program; or

"(bb) provided under arrangements made by the hospice program.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the date that is six months after the date of the enactment of this Act.