AACN
American Academy of Clinical Neuropsychology

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September 12, 2025
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via Regulations.gov

Re: CMS-1832-P RIN 0938-AV50 Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements

To Whom it May Concern:

This letter is being submitted on behalf of the American Academy of Clinical Neuropsychology (AACN) to provide comments on the proposed rule on the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) released by the Centers for Medicare and Medicaid Services (CMS) on July 14, 2025.

We appreciate the efforts of CMS to respond to the current mental and behavioral health crisis. We especially appreciate CMS' efforts to improve equitable access to mental and behavioral health treatment, not just through this proposed rule but in its efforts throughout the year.

Executive Summary of AACN Key Issues Addressed

- Telehealth Services
- Digital Therapeutics
- Valuation of Specific Codes
- Advanced Primary Care Management Services
- Updates to the Quality Payment Program
- Social Determinants of Health Assessment and Community Health Integration Services

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AACN is an organization of professionals certified through the American Board of Clinical Neuropsychology. AACN's membership also includes non-certified affiliates, post-doctoral fellows, and students/trainees. Clinical neuropsychology is dedicated to understanding the relationship between brain and behavior, particularly as applied to the diagnosis of brain disorders, assessment of cognitive and behavioral functioning, and the design of effective treatment.

AACN membership includes over 3000 individuals. AACN's mission is to advance the profession of Clinical Neuropsychology through its advocacy of outstanding educational and public policy initiatives. Our members provide critically needed neuropsychological services to Medicare beneficiaries. This includes psychological and neuropsychological testing, consultations to other providers, health behavior assessments and interventions for beneficiaries struggling with physical health problems, including but not limited to traumatic brain injuries, strokes, epilepsy, multiple sclerosis, dementia (i.e., Alzheimer's disease), movement disorders, developmental delays, and autism spectrum disorder.

Many of the patients that AACN members serve reside in underserved communities and rural areas and have long struggled to access critical services. As the agency finalizes this rule, we ask that CMS continue to advance the goal of achieving equitable access to care in these communities.

We applaud CMS for taking action to increase beneficiary access to behavioral health services and offer the following recommendations to strengthen the Medicare program and influence health policy for both Medicaid and commercial payers.

Telehealth Services

Telehealth has become an essential tool for expanding access to neuropsychological, mental health, and behavioral health services. Telehealth services reduce barriers such as travel, mobility challenges, and provider shortages—particularly in rural and underserved areas—while ensuring that patients can connect with specialized care more quickly. By offering secure, flexible, and convenient options, telehealth helps bridge gaps in service delivery, supports continuity of care, and promotes better health outcomes for individuals who might otherwise go without needed a needed neuropsychological evaluation or treatment.

<u>Status of Services Already Approved with Provisional Status</u>
CMS proposes to streamline the process for adding services to the list of telehealth services eligible for Medicare coverage. Because, under these new criteria, CMS has already determined that "services with a 'provisional' designation satisfy the [new] standards…in prior rulemaking cycles," CMS concludes that "[no] further review would be required to justify their inclusion on the Medicare Telehealth Services List."
Comment: The commendable efforts by CMS and Congress to expand access to telehealth services over the past several years not only extended the reach of behavioral health practitioners in rural and

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underserved areas but also improved clinical efficiencies in treatment. In the early days of the COVID-19 pandemic, a bipartisan consensus in Congress, assisted by multiple federal agencies, sought to waive certain longstanding coverage restrictions on telehealth coverage. For the first time, a broader array of mental and behavioral health services—including psychological and neuropsychological testing services—were covered as telehealth services. Fortunately, mental and behavioral health services can be provided as telehealth services with no decrease in the quality or effectiveness of that service. APA applauds CMS for placing its trust in clinicians, not government officials, to select the form of mental and behavioral health treatment that best furthers the objectives of such treatment.
Recommendation: AACN fully supports CMS' proposal to add all codes currently designated as "provisional" to the permanent Medicare Telehealth Services List. In so doing, CMS enables clinicians to exercise their best judgment as to the modality of treatment that is most effective for a specific patient. AACN strongly recommends that CMS finalize this proposal as written.

Direct Supervision via Use of Two-Way Audio/Video Communications Technology

CMS proposes to adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner via a virtual presence using audio/video real-time communications technology, with the exception of services that have a global surgery indicator.
Comment: AACN strongly supports this change in supervision policy as a means of improving timely access to mental and behavioral health services. In clinical practice, a supervising clinician may not always be located in the same building or campus. This is especially true in rural and other underserved communities where clinical sites may be located miles apart. The physical presence of a supervising clinician does nothing to improve the supervisory relationship with trainees or other supervised clinicians. By adopting a more flexible approach to supervision, CMS recognizes the practical realities of clinical supervision.
Recommendation AACN urges CMS to finalize its proposed definition of "direct supervision" to allow the "immediate availability" of the supervising practitioner via two-way audio/video communication.

Direct Supervision via Communications Technology for Teaching Physicians and Critical Resident-Furnished Services

CMS proposes not to extend the current virtual direct supervision policy for teaching physicians. Under this proposal, for services provided within Metropolitan Statistical Areas (MSAs), teaching physicians must be physically present during the critical portions of all resident-furnished services to qualify for Medicare payment, not just in-person services, to ensure consistent oversight standards. However, CMS would maintain flexibility for services provided outside MSAs; in rural settings, teaching physicians could continue using real-time audio/video technology to meet the presence requirement, as long as they actively observe and participate in the service.

Comment: Urban areas face significant provider shortages. Academic medical centers in these areas often rely on virtual tools to expand supervision capacity and manage high patient volumes. Maintaining virtual presence flexibility across all geographies ensures continued access to care, supports clinical training, and allows teaching physicians to provide timely oversight without compromising patient safety or care quality.

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Recommendation: AACN urges CMS to extend this virtual supervision flexibility to MSAs as well.

In the proposed rule, CMS states *"Physicians must maintain physical presence during critical portions of all resident-furnished services to qualify for Medicare payment."*

Comment: We are concerned that this language may significantly alter longstanding supervision norms, especially for Evaluation and Management (E/M) services. The proposed phrasing suggests that the attending physician must be physically present and concurrently perform or observe the "key and critical portions" of the service in real time, effectively requiring a side-by-side or "over-the-shoulder" model during the entirety of the critical service delivery. This interpretation, if enforced, would impose a stricter requirement than what is currently applied in-person, and could create confusion, compliance risk, and operational disruption for academic medical centers, teaching hospitals, and digital health programs - many of which rely on telehealth to extend supervisory reach. Ultimately, this type of restriction would disrupt critical care for Medicare beneficiaries.

Recommendation: AACN urges the Agency to clarify that it does not intend to alter longstanding supervision norms for resident-furnished services.

Pending Requests to Add to the Telehealth Services List

CMS proposes adding two additional codes to the permanent Medicare Telehealth Services List: Multiple-Family Group Psychotherapy (CPT 90849) and Group Behavioral Counseling for Obesity (G0473).

Comment: *Group Behavioral Counseling for Obesity (G0473)* is a common form of intensive behavioral therapy (IBT) for treatment of obesity. There is ample evidence demonstrating that this treatment, which is similar to several other group codes (90853 and 96164), can be provided via telehealth.

Multiple-Family Group Psychotherapy (CPT 90849) is a form of group psychotherapy involving interactions with multiple patients to facilitate a supportive environment, whereby patients can learn from one another's experiences and gain insights from group dynamics. This type of psychotherapy can be particularly effective for mental health issues such as anxiety, depression, and interpersonal problems, among others. Other forms of group psychotherapy (including CPT 90853) are already included on the permanent Medicare Telehealth Services List, demonstrating the ability of this service to be delivered via telehealth.

Recommendation: AACN recommends that CMS promptly move forward with adding these two codes to the permanent Medicare Telehealth Services List.

Telehealth Policies Not Addressed in CY 2026 Medicare PFS Proposal

In March, Congress extended the following flexibilities through September 30, 2025:

- Waiving originating and geographic site requirements
- Audio-only coverage
- Expansion of Medicare telehealth provider list to include therapists

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- Allowing Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to serve as distant sites
- Temporary waiver of tele-mental health in-person visit requirement
- Continuation of Acute Hospital Care at Home Program

Recommendation: AACN requests CMS to work alongside Congress to make permanent or extend these flexibilities for as long as possible before the end of September. Following an extension, it is critical that CMS releases aligning regulatory guidance as soon as possible to reduce confusion amongst the industry.

Telehealth Provider Address Location Flexibility Permanent
CMS has a temporary policy allowing providers who deliver telehealth services to list their affiliated practice address, rather than their home address, on Medicare billing and enrollment forms.
Comment: This flexibility has supported provider retention, expanded access to after-hours care, and helped grow telehealth capacity across the country. However, this policy is set to expire on December 31, 2025. If CMS reverts to requiring home addresses or other locations of care, it will raise serious privacy and safety concerns for clinicians and significantly increase administrative burdens for providers and health systems alike.

Such a change would impact multiple stakeholders. For providers, it could discourage telehealth participation, exacerbate burnout, and reduce overall capacity. Health systems would face added labor costs and operational complexity. For CMS, the proposed shift would likely increase processing demands and staffing needs. Most importantly, patients could face longer wait times and reduced access to care due to fewer available providers, counter to the goals of expanded telehealth utilization.

We applaud CMS for incremental progress, such as the updated CMS-855i form and the allowance of P.O. boxes for enrollment. However, this change does not address billing forms, and the CY2026 Physician Fee Schedule draft rule does not address this important issue.
Recommendation: AACN urges CMS to finalize and formalize the current flexibility, allowing providers to permanently use their affiliated practice addresses for billing.

Digital Therapeutics

Digital therapeutics offer psychologists innovative tools that enhance clinical efficiency while expanding access to care. By integrating evidence-based digital platforms into treatment, psychologists can streamline routine interventions, monitor patient progress in real time, and extend support between sessions. This not only frees clinicians to focus on more complex aspects of care but also makes high-quality, personalized treatment more widely available, particularly for individuals facing barriers to in-person services.

Updates to Payment for Digital Mental Health Treatment (DMHT)

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Digital Therapy Device for Attention Deficit Hyperactivity Disorder (ADHD).
CMS is proposing to expand our payment policies for HCPCS codes G0552, G0553, and G0554 to also make payment for DMHT devices cleared under section 510(k) of the FD&C Act or granted De Novo authorization by FDA and in each instance classified at § 882.5803 Digital therapy device for Attention Deficit Hyperactivity Disorder (ADHD).

Comment: ADHD is a common and often untreated disorder. Accessing evidence-based behavioral treatment for ADHD is often a difficult task for patients and families. Having access to digital behavioral therapy devices for ADHD will allow psychologists to provide services more efficiently, increase the number of patients they serve, and increase access to care.

Recommendation: AACN supports the proposal to expand coverage to include digital therapy devices for Attention Deficit Hyperactivity Disorder (ADHD).

Computerized behavioral therapy devices for treating symptoms of gastrointestinal conditions at § 876.5960; Digital therapy devices to reduce sleep disturbance for psychiatric conditions at § 882.5705; and Computerized behavioral therapy device for the treatment of fibromyalgia symptoms to be codified at § 882.5804.
CMS requests comments on establishing coding and payment policies for devices classified under the following FDA regulation sections that were recommended to the agency by interested parties: Computerized behavioral therapy devices for treating symptoms of gastrointestinal conditions at § 876.5960; Digital therapy devices to reduce sleep disturbance for psychiatric conditions at § 882.5705; and Computerized behavioral therapy device for the treatment of fibromyalgia symptoms to be codified at § 882.5804.

Comment: Devices classified under 21 CFR 876.5960: Computerized behavioral therapy device for treating symptoms of gastrointestinal conditions can help mitigate behavioral health workforce shortages. There are currently 3 devices classified under 21 CFR 876.5960. All are indicated for treatment of irritable bowel syndrome (IBS), a condition for which Medicare beneficiaries struggle to access the full range of clinically appropriate treatments, including psychotherapy.
Irritable bowel syndrome (IBS) is a chronic, often debilitating, and highly prevalent disorder of gut-brain interaction.[1] IBS is a common source of referrals to gastroenterologists with a prevalence of approximately 4.4%–4.8% in the United States.[1] IBS is associated with high healthcare resource utilization.
The American College of Gastroenterology recommends gut-directed psychotherapies as part of IBS management protocols in clinical guidelines.[1] Gut-directed psychotherapies, which as a class include cognitive-behavior therapy (CBT)-GI and gut-directed hypnotherapy (GDH), improve IBS symptom severity by targeting the cognitive and affective factors known to drive symptom experience. These

[1] Lacy, B. E., et al. (2021). ACG clinical guideline: management of irritable bowel syndrome. Official journal of the American College of Gastroenterology| ACG, 116(1), 17-44.

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targeted psychotherapies are typically delivered by behavioral health specialists, such as psychologists, and are often difficult to access for Medicare beneficiaries.

Computerized behavioral therapy devices for the treatment of fibromyalgia symptoms to be codified at § 882.5804: Fibromyalgia is a chronic, complex, and prevalent condition that significantly impacts patients' lives and has mental and behavioral health disorders as core symptoms. Fibromyalgia is characterized by widespread pain, accompanied by debilitating symptoms including depression, anxiety, sleep disturbances, fatigue, and cognitive dysfunction ("fibro fog").[2] Mental and behavioral health symptoms are such an important component of fibromyalgia that presence of depression, cognitive disturbances, and sleep disturbances are included as components of the diagnostic criteria for fibromyalgia.[3] The Revised Fibromyalgia Impact Questionnaire, the gold standard in assessing fibromyalgia severity, also includes the mental and behavioral health symptoms of depression, anxiety, sleep disturbance, and cognitive disturbance as individual components of the total score.[4]

CBT is a validated treatment for fibromyalgia symptoms that is recommended in US treatment guidelines. Given the multifaceted nature of fibromyalgia, US treatment guidelines consistently recommend Cognitive Behavioral Therapy as a cornerstone for management of fibromyalgia.[2,5,6] CBT has demonstrated clinically validated benefits for managing fibromyalgia symptoms and has been shown to improve core fibromyalgia symptoms including pain, fatigue, functional ability, and mental and behavioral health symptoms of depression, anxiety, and sleep disturbances. From a behavioral therapy standpoint, there is no distinction in the clinical effectiveness of CBT for treating fibromyalgia symptoms, including mental and behavioral health symptoms, compared to CBT for conditions currently included in the DMHT policy, including depression, anxiety, insomnia, and substance use disorders.

Fibromyalgia patients' needs are unmet because, despite the evidence, there is a lack of access to specialized CBT for fibromyalgia. Real world access to CBT for fibromyalgia is currently limited by a lack of behavioral health specialists, few treatment centers, referral barriers, and high costs. Annually, only 4.5% of patients with fibromyalgia have reported using CBT.[7] Patients with fibromyalgia incur

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[2] Clauw DJ. Fibromyalgia: A Clinical Review. *JAMA* 2014; **311**: 1547–55.
[3] Wolfe F, Clauw DJ, Fitzcharles M-A, *et al.* 2016 Revisions to the 2010/2011 fibromyalgia diagnostic criteria. *Seminars in Arthritis and Rheumatism* 2016; **46**: 319–29.
[4] Bennett RM, Friend R, Jones KD, Ward R, Han BK, Ross RL. The Revised Fibromyalgia Impact Questionnaire (FIQR): validation and psychometric properties. *Arthritis Res Ther* 2009; **11**: R120.

[5] Buckhard C, Goldenberg DL, Crofford L. Guideline for the management of fibromyalgia syndrome pain in adults and children. *American Pain Society* 2005; **109**.
[6] Winslow BT, Vandal C, Dang L. Fibromyalgia: Diagnosis and Management. *AFP* 2023; **107**: 137–44.
[7] Robinson RL, Kroenke K, Mease P, *et al.* Burden of Illness and Treatment Patterns for Patients with Fibromyalgia. *Pain Med* 2012; **13**: 1366–76.

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considerable direct and indirect healthcare costs, emphasizing the need for effective and accessible management strategies.

Psychologists are the type of behavioral health specialists that provide evidence-based CBT for both IBS and fibromyalgia. Having access to these digital behavioral therapy devices will allow psychologists to provide services more efficiently, increase the number of patients they serve, and increase access to care for patients with both IBS and fibromyalgia.

Recommendation: AACN strongly encourages the Agency to expand the DMHT codes to include the above device classifications for CY 2026.

Contractor-priced Status for HCPCS code G0552

CMS does not believe they can appropriately price all the DMHT devices for which they would make payment under our current policies and proposals, and therefore, are not proposing any changes to the existing contractor-priced status for HCPCS code G0552. The agency welcomes information and may consider national pricing through future rulemaking.

Comment: One hurdle to adoption is practitioner unwillingness to use codes if claims are not processed and paid in a timely manner, and another is concern regarding fair and accurate pricing. Practitioners cannot be expected to invest in new healthcare technologies without having information about what the financial impact will be on their practice.

Unfortunately, the Medicare Administrative Contractor (MAC) pricing process has been slow, and the MACs are questioning DMHT coverage. Furthermore, there are concerns about fair and accurate pricing for DMHT devices which seems to be driven by a continued lack of understanding between various types of technologies (e.g. unregulated wellness apps, remote monitoring devices, and DTx) and when use of DMHTs would be considered medically necessary. With respect to the clinical questions, various stakeholders believe that lack of behavioral health specialist involvement in the MAC coverage determination process for DMHTs could be a contributing factor. Skepticism regarding the use of invoices for pricing and the value of FDA requirements for DMHTs also contribute to pricing and claims processing difficulties.

While the professional DMHT treatment management services may have physician work and practice expense inputs that are similar to the treatment management services for remote therapeutic monitoring (RTM- CPT codes 98980 & 98981), DMHT devices are substantially different from devices used for RTM. Regarding code valuation, DMHT devices have substantially different practice expense inputs which reflect the fact that they are therapies designed to treat, manage or prevent a mental health condition, as opposed to RTM devices which are designed to collect and transmit data back to the treating practitioner. Furthermore, it is not appropriate to crosswalk DMHT devices which have gone through the FDA process to technologies that are reimbursed but are not subject to the same level of

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regulatory requirements. It is our understanding that the MACs may not appreciate these distinctions, resulting in unfair and inaccurate pricing for devices that qualify for coverage under G0552.

Recommendations:

1) Establish a national temporary price for G0552 for 2026 based on existing claims data or appropriate cross walk to promote utilization.
   If the agency will not establish a temporary national price for G0552, we make the following recommendations:
2) Provide guidance to the MACs regarding the appropriate considerations for evaluating the medical necessity of a G0552 device and establishing pricing (i.e., DMHT specific data);
3) Instruct the MACs to develop a timely and transparent process for G0552 device claims review;
4) Require that individuals with behavioral health expertise be involved in the coverage determination and claims review processes.

<u>FDA Authorized Eye-Tracking Technology to Aid in the Diagnosis of Autism</u>

CMS is requesting comments on other related digital device policies for our consideration in future rulemaking. Specifically, CMS received a request from an interested party to create a new add-on G code to existing CPT codes 96112, 96113, 96116, 96121, 96130, 96131, 96132, and 96133 for physicians' or nonphysician practitioners' psychological/neuropsychological evaluations so they may report administration of an FDA authorized eye-tracking technology to aid in the diagnosis of Autism Spectrum Disorder (ASD) in pediatric patients, including staff time with the patient, data submission and output.

Comment: AACN does not believe a new add-on G code to existing CPT codes 96112, 96113, 96116, 96121, 96130, 96131, 96132, and 96133 is appropriate. Although a provider may use this service and developmental testing and/or psychological & neuropsychological evaluations codes in the process of assessing and diagnosing an individual with autism, the technology and service described by the interested party represents a different service that is separate and distinct from the existing developmental testing and psychological & neuropsychological evaluations codes. An add on code would be inappropriate. Because the service is separate and distinct from existing codes and is dependent on an FDA authorized technology, a specific code should be established for this service, either as a G code by CMS or through the AMA's CPT code process.

Recommendations:

1) CMS should **not** create a new add-on G code to existing CPT codes 96112, 96113, 96116, 96121, 96130, 96131, 96132, and 96133 for this new FDA authorized eye-tracking technology to aid in the diagnosis of Autism Spectrum Disorder (ASD).
2) A new and specific code should be established for this service, either as a G code by CMS or through the AMA's CPT code process.

<u>Remote Therapeutic Monitoring (Device Supply for Cognitive Behavioral Therapy)</u>

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CMS is recommending Remote Monitoring Services 98XX6 and 98978 be contractor priced and is not accepting the RUC HCPAC Review Board recommended practice expense (PE) inputs for CPT codes 98XX6 and 98978.

Code	Long Descriptor	CMS Proposed work RVU	RUC Recommended work RVU
98XX6	**Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 2-15 days in a 30-day period**	**PE Only / Contractor Priced**	**PE Only**
98978	**Remote therapeutic monitoring (eg, therapy adherence, therapy response, digital therapeutic intervention); device(s) supply for data access or data transmissions to support monitoring of cognitive behavioral therapy, 16-30 days in a 30-day period**	**PE Only / Contractor Priced**	**PE Only**

Comment: This service was reviewed at the January 2025 RUC meeting, and the professional organizations were able to identify the device most commonly used for this service. The recommended digital therapeutic device is an FDA-authorized product that helps healthcare providers conduct remote therapeutic monitoring to track patients' therapeutic progress and symptom status. These services and related digital therapeutic devices are for monitoring only. It is a $50 monthly fee, per patient. This is supported by the original invoices submitted. Since CPT codes 98978 and 98XX6 are inextricably linked, it makes sense that they have the same supply input. Further, both codes were placed back on the new technology / new services list to be reviewed in three years to ensure correct valuation, patient population, and utilization assumptions. Therefore, we believe it is inappropriate to maintain contractor pricing for either service as the appropriate supply input has been identified and there is an expected re-review of the service in three years.

Recommendation: AACN urges CMS to accept the input of a digital therapeutic device supply item as submitted by the professional organization for CPT codes 98XX6 and 98978.

Valuation of Specific Codes

Decreased Medicare reimbursement threatens both patient access and provider participation. Lower rates make it increasingly difficult for neuropsychologists to sustain services under Medicare, leading many to limit or withdraw from participation. As a result, patients—particularly older adults who rely

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on specialized cognitive and behavioral health assessments—face longer wait times, reduced availability of providers, and barriers to timely, high-quality care.

Non-Facility PE RVU Reductions (Codes 96112, 96132, 96179, and 96179)

Despite overall increases in Medicare payment for behavioral health services, critical psychological and neuropsychological testing services are expected to receive a reduction in national average non-facility payment. Preliminary analysis suggests that this decrease stems from a technical calculation CMS uses to determine if a service meets specific criteria for the fee schedule's indirect practice expense (PE) floor, a minimum value in its PE RVU calculation intended to improve reimbursement for eligible services furnished in an office setting.

These codes meet CMS technical screens to receive this adjustment in 2025 but miss the technical screen by the slimmest of margins in the 2026 proposed rule calculations, resulting in unexpected year-over-year payment fluctuations. For a code to be eligible for the adjustment to allocation of indirect practice expense (alternative methodology for indirect PE), several screens must be met including a ratio of less than 0.4 non-facility PE RVUs for each work RVU.

Ration of PE RVU to Work RVU		
Codes	**CY 2025**	**Proposed CY 2026**
96112	**0.36999**	**0.40866**
96132	**0.35648**	**0.41619**
96170	**0.39829**	**0.44949**
96171	**0.39896**	**0.45021**

Comment: Although appreciative of CMS' efforts to improve reimbursement for outpatient behavioral health services, **AACN** fears that some of these actions are unintentionally resulting in actual lower reimbursement for codes 96112 and 96132 which are critical to the proper assessment of developmental and neuropsychological conditions, and 96170 and 96171 which play an integral role in the management of chronic illness. While we continue to appreciate the fee schedule's use of the indirect PE floor for certain services, this current eligibility screen produces payment instability for services that are often on the cusp of eligibility. For example, in recent years, developmental testing and neuropsychological testing services have been finalized as both eligible and ineligible, often

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dependent on the tenth or hundredth decimal point place in the service's non-facility PE RVU for that particular year. This anomaly has produced double digit percentage fluctuations year-over-year in these services' non-facility PE RVUs and runs counter to CMS's stated goal of payment stability and predictability within the fee schedule. To correct this anomaly, we request CMS reform the eligibility screening methods for the indirect PE floor.

Recommendations:

1) **AACN** asks CMS to use a rolling three-year average of each services' non-facility PE and work RVUs when screening for the 0.4 non-facility PE to work RVU ratio, similar to the agency's use of an average of three years of claims data when calculating a code's specialty mix.
2) We also urge CMS to release eligibility calculations in each year's proposed rule for improved transparency into the technical screen.
3) Given the distinct possibility of broader PE methodology changes in the coming years, we also ask that CMS adopt a one-year notice period before finalizing a previously eligible code as newly ineligible for the indirect PE floor. If, after notifying the public of a service's new ineligibility for the indirect PE floor, the code continues to exceed the 0.4 non-facility PE RVU to work RVU ratio, we recommend CMS finalize the code's ineligibility.

Together, these changes will continue to provide much needed support for services with very low direct PE inputs, while also shielding the services from consequential year-over-year payment swings due to negligible fluctuations in their non-facility PE RVU valuation.

Advanced Primary Care Management Services

APCM Behavioral Health Integration (BHI) Add-On Codes (HCPCS Codes GPCM1, GPCM2, GPCM3)

CMS is proposing to finalize a set of Behavioral Health Integration (BHI) add-on codes for use in conjunction with Advanced Primary Care Management (APCM) services. These codes are intended to better reflect the clinical and operational realities of delivering integrated behavioral health care coordination in primary care, while reducing billing complexity and promoting sustainability.

Comment: AACN strongly supports CMS's proposal to establish new BHI add-on codes (GPCM1, GPCM2, and GPCM3) for use in conjunction with APCM services. This represents an important step forward in supporting delivery of behavioral health care coordination as a foundational element of high-quality primary care. By simplifying billing requirements and eliminating rigid time thresholds, these codes would be more accessible than existing codes for primary care across all settings, including small, independent, and rural practices where the need for integrated services is often greatest.

It is important to note, however, that these codes are designed to capture the care coordination functions of behavioral health integration, such as communication between primary care and behavioral health providers, follow-up with patients, and adjustment of care plans, rather than the provision of direct behavioral health treatment. This distinction underscores the value of care coordination in integrated models, but it also highlights the need for future payment approaches that fully recognize and support behavioral health clinicians' role in delivering treatment within primary care. AACN

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encourages CMS to continue building on the foundation established with these add-on codes by developing future models that reimburse evidence-based behavioral health treatment as part of comprehensive, team-based primary care.

Recommendations:

1) AACN urges CMS to ensure that the new Behavioral Health Integration (BHI) add-on codes under the Advanced Primary Care Model (APCM) are available to beneficiaries without cost sharing. Even modest copayments can create a significant barrier to accessing behavioral health services, particularly for older adults and those with chronic conditions who already face high out-of-pocket costs. Eliminating cost sharing for these codes would reduce financial barriers, promote early engagement in care, and increase the likelihood that beneficiaries can benefit from integrated behavioral health services in primary care. As CMS notes, effective care management within advanced primary care practice requires balancing prevention and treatment for optimal patient care. This is true for physical and chronic conditions, behavioral health disorders, and behavioral health integration services.
2) AACN urges CMS to waive APCM BHI add-on codes from counting toward cost measures. In programs such as the Medicare Shared Savings Program (MSSP), cost benchmarks are set to reflect the expected costs of patient care. However, these benchmarks do not currently account for the costs of implementing integrated MH/SUD care or billing the new Behavioral Health Integration (BHI) add-on codes under the APCM. If practices begin using these codes, their costs will appear artificially higher, and this could count against them in cost-based programs—even though integrated behavioral health has the potential to reduce costs over time. To avoid creating this unintended disincentive, AACN urges CMS to waive the costs of the APCM BHI add-on codes from consideration in all cost measures for several years. This temporary protection would encourage practices to adopt the codes, give CMS time to collect data on utilization and outcomes, and ultimately support the broader goal of advancing integrated behavioral health in primary care.
3) AACN urges CMS to consider increasing incentives for primary care practices—both those participating in the new APCM payment model and those who do not—to adopt behavioral health integration services using the 99484, G0323, and GPCM3 codes. This could be done by increasing the valuation for these codes, or allowing their use more frequently than once per month per patient. For the most recent year for which data is available, G0323 was utilized on a nationwide basis a total of only about 3,000 times. The 99484, G0323, and proposed GPCM3 codes for general behavioral health integration services are appropriate for billing for patient care provided under the Primary Care Behavioral Health model, in which a psychologist or other behavioral health specialist practices within the primary care practice team to provide whole-person care, From 2022 to 2023, use of the 99484 and G0323 codes increased at a far slower rate than billing under the CoCM codes. While we support all evidence-based models of integrated care, we are concerned about the "low and slow" adoption of PCBH and related non-CoCM models of integrated care.
4) AACN recommends that CMS measure and then establish national targets for access to integrated MH/SUD services and monitor progress through claims and quality measure data. Public reporting on the uptake of APCM and BHI services could inform future policy, highlight best practices, and accelerate adoption of integrated models nationwide.

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APCM Services Provided by FQHCs/RHCs and Integrated Behavioral Care

CMS also proposes to adopt certain add-on codes for APCM that would allow Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to bill for behavioral health integration (BHI) and collaborative care services (CoCM) when providing this service. CMS believes that allowing for the use of these codes would encourage RHCs and FQHCs to provide complementary behavioral health integration services, boosting access to behavioral health care for primary care patients in the RHC and FQHC settings.

Comment: Many behavioral health practitioners, particularly those in rural and underserved areas, utilize a team-based, interdisciplinary approach to treating the whole health of a patient. Several care settings, including FQHCs and RHCs, can utilize some form of integrated care to expand their service offerings to include behavioral health integration. However, given the confusing and often inconsistent forms of coding for these services and concern about effective management of clinical resources, many of these settings fail to take advantage of this opportunity. Because they provide a clearer pathway to coverage, AACN agrees that these add-on codes are likely to incentivize these settings to adopt integrated care services.

Recommendation: AACN encourages CMS to finalize its proposal concerning coding of behavioral health integration services in RHCs and FQHCs, including its requirement for these settings to bill the individual codes that constitute the current G0512 code.

Updates to the Quality Payment Program and Medicare Promoting Interoperability Program

Creating more opportunities for psychologists to participate in Medicare's Quality Payment Programs is essential for advancing patient care and system-wide improvement. Expanding inclusion ensures psychologists can contribute their expertise in mental and behavioral health to value-based care initiatives, promotes alignment with broader healthcare quality goals, and incentivizes high-quality, evidence-based services for Medicare beneficiaries.

CY 2026 Modifications to the Quality Payment Program and Data Submission

CMS requests comments on proposals to expand the MVP portfolio with six new MVPs, develop new potential MVPs, end traditional MIPS in the future, maintain MIPS final score methodology and payment adjustment, and improve data quality and interoperability.

MIPS Value Pathway (MVP) Development, Maintenance, and Scoring

Comment: AACN appreciates the desire by CMS to address providers' concerns regarding quality payment reporting burden. MIPS Value Pathways (MVPs) and their core measure sets may address this burden, which is why, in collaboration with the National Academy of Neuropsychology, we proposed the *Promotion of Optimal Neuropsychology Consultation MVP* in 2023. We were extremely pleased to see this MVP was posted for the 2026 MVP Candidate Feedback Period and was subsequently moved forward to rulemaking. We strongly support CMS finalizing this new MVP for neuropsychology but request that *MBHR11: Cognitive Assessment with Counseling on Safety and Potential Risk* and

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MBHR16: Comprehensive Cognitive Assessment Assists with Differential Diagnosis be reinstated in the MVP per our original submission.

As a clinical specialty, neuropsychologists provide healthcare to a wide diversity of clinical populations across the lifespan. Aging populations experiencing neurocognitive decline associated with neurodegenerative syndromes are certainly part of this population mix, but this population accounts for only about 25% of their profession's clinical services. The measures included in the new MVP have been developed to reflect the unique practice patterns of their profession and to provide coverage across this diversity of clinical populations served by neuropsychologists. The neuropsychology QCDR measures have also been constructed to support measure reporting within the unique consultation model of service provision that the majority of their profession engages in. Further, inclusion of MBHR 11 and 16 are critical, as they measure quality for indications other than dementia.

Further, given that the majority of Medicare providers who report MIPS within our registry are treating patients in long-term care (LTC) settings, we urge CMS to consider adopting a LTC mental health MVP with meaningful measures to patients and providers to promote CMS' proposed Behavioral Health Strategy. We recommend focusing on three key areas: 1) substance use disorder (SUD) prevention, treatment and recovery services, 2) ensuring effective pain treatment and management, including nonpharmacological therapies, and 3) improving mental health care and services[8]. In addition, CMS expects LTC facilities to ensure that staff are adequately trained to meet the behavioral health needs that are unique to these residents. Regulation F740 Behavioral Health Services states that the behavioral health care needs of those with a SUD or other serious mental disorder should be part of the facility assessment under §483.70(e) (F838), and that the facility should determine if they have the capacity, services, and staff skills to meet the requirements as discussed in F741[9]. However, there are no corresponding MIPS process measures to reflect that a provider or facility has met these requirements. We have proposed three new QCDR measures in our 2026 self-nomination to address this gap.

The importance of focusing on meeting the emotional and behavioral health needs of residents in LTC settings should be a priority. This population was at the epicenter of the COVID-19 pandemic, and there is continued research examining its impact on their emotional wellbeing[10]. We also know that staff in LTC settings rely on mental health providers for guidance on avoiding mental health related F-tags related to conditions that include avoiding re-traumatization of residents with prior trauma exposure, providing essential substance abuse treatment to residents with current substance issues, appropriately diagnosing schizophrenia and other psychotic disorders for those residents receiving antipsychotic

[8] CMS Behavioral Health Strategy | CMS

[9] State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities Resource Location: https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

[10] Lind, L.M., Ward, N., Rose, S., & Brown, L.M. (2022). The impact of the COVID-19 Pandemic on psychological service provision, mental health practitioners, and patients in long-term care settings: Results from a rapid response survey. Professional Psychology: Research and Practice, 54(1), 93–102.

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medication, and providing appropriate nonpharmacological interventions for those residents who are undergoing a gradual dose reduction of psychotropic medication, just to name a few.

Recommendations:
1. AACN encourages CMS to finalize approval of the *Promotion of Optimal Neuropsychology Consultation MVP* with the added inclusion of MBHR11 and 16.
2: AACN encourages CMS to support APA in developing a new MVP and approve the three new process measures that are clinically relevant to many Medicare beneficiaries being seen in LTC settings.

Sunsetting of MIPS to MIPS Value Pathways

Comment: MVPs are not likely to be feasibly implemented for psychologists who have generalist practices and see between 30 – 40 patients per week who present with varying diagnoses (e.g., depression, anxiety, PTSD, psychosis, etc) and represent patients across the lifespan. MVPs, which are essentially core measure sets, may address quality payment reporting burden but are only likely to be feasibly implemented for certain settings, such as long-term care, or for certain subspecialty provider populations, such as neuropsychologists. No single core measure set, including the existing *Quality Care in Mental Health and Substance Use Disorder MVP*, could account for the level of patient heterogeneity a generalist psychologist provides treatment to, and having to implement multiple different MVPs would increase the burden that ECs currently experience with traditional MIPS. One solution would be to retain traditional MIPS for those providers for whom no MVPs are relevant or are not feasibly able to be implemented and instead reduce the number of quality measures reported from 6 to 4 to better align with MVPs, and reduce burden while giving providers adequate options in selecting the measures that are most meaningful to their particular patient population.

Recommendation: AACN encourages CMS to retain traditional MIPS for those providers for whom no MVPs are relevant or are not feasibly able to be implemented and instead reduce the number of quality measures reported from 6 to 4 to better align with MVPs.

Maintaining Stability

Comment: AACN appreciates CMS' efforts toward stability by maintaining the MIPS program established performance threshold and data completeness criteria. Basing the minimum performance threshold upon the mean or median of the final scores of all MIPS eligible clinicians (ECs) is an unfair and premature standard to apply to clinical psychologists, who have relatively few MIPS reporting measures to choose from. Of the 198 existing MIPS Quality Measures available for 2023, only 21 measures are applicable to mental health providers; of those, only 12 measures have been benchmarked, six (6) of which have a maximum score of 7 points. This leaves psychologists with far fewer opportunities to amass points compared to ECs in other specialties. A "one-size-fits-all" approach simply does not make sense. Further, the proposal to discontinue automatic reweighting of PI for clinical psychologists will add an additional burden within an already burdensome program.

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It will be extremely difficult for psychologists to increase their number of points in just one year to avoid a 9% penalty, particularly in light of the quality measure scoring challenges described above. If the threshold is raised in 2025, more clinical psychologists will be penalized than has occurred in any other year, risking the departure of clinical psychologists from Medicare for years to come. This departure would reduce access to vital psychotherapy, testing, assessment, health behavior, and integrated care services for older Americans and people with disabilities.

Recommendation: AACN supports CMS's decision to continue to retain the current minimum performance threshold of 75 points for MIPS reporting and maintain that threshold through the 2030 MIPS payment year.

Measure/Activity Inventories and Scoring Methodologies

Comment: AACN appreciates the new measure benchmark scoring for topped out measures but believes that falls short of addressing the overall challenges with the way benchmarks for all measures are currently established. Benchmarks are currently established by calculating the number of provider Taxpayer Identification Numbers (TINs), as opposed to the number of National Provider Identifiers (NPIs), having reported on a measure. This approach disenfranchises specialties that have low numbers of required reporters, making it impossible to get most QCDR quality measures benchmarked, regardless of how relevant and meaningful they are to that provider and patient population. Since its inception in 2018, APA's Mental and Behavioral Health Registry (MBHR) continues to receive CMS approval with 11 QCDR measures developed specifically for mental and behavioral health providers to enable them to successfully participate in MIPS, by reporting measures that are meaningful to their practice.

The unintended consequence of this benchmarking approach is that eligible clinicians (EC's) are strongly disincentivized from reporting on these specialty measures and instead choose measures they know they can score enough points on to avoid a payment penalty. For example, when looking at the 2023 reporting year performance data of MBHR 2: Anxiety Response to Treatment, we had over 515 providers who administered the measure, but only 18 TIN organizations submitted, which prevented it from being benchmarked in 2024. Participating psychologists are at risk of having most, if not all, of the 11 QCDR measures rejected every year due to lack of measure adoption, resulting in the inability to obtain benchmarks in part because of the way benchmarks are currently calculated.

The American Psychological Association (APA) has prioritized the development and implementation of patient-reported outcomes measures (PROS); 5 of APA's 11 measures are PROS. However, it has also become clear that there is a clinical need for additional process measures, which are particularly critical to neuropsychologists and providers in LTC settings as these care models typically involve only one or two meetings with the Medicare beneficiary, with brief or no ongoing relationship. While we appreciate the approval of a new process measure, *Trauma Screening and Re-Traumatization Measure (MBHR19),* in our registry for 2025, it has been historically very challenging to get QCDR process measures approved. In addition, the CMS MIPS and QCDR quality measure approach is restricted to the calendar

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year. The restricted measurement interval of the calendar year has several shortcomings in assessing care quality at the provider level, as time 1 and time 2 administrations of an outcome measure may not fall within the calendar year making the performance "not met." Although there have been studies investigating quality in public behavioral healthcare settings, these studies have singularly focused on continuous outcome feedback to the provider yielded from patient-reported outcome measures[11, 12, 13]. Outcomes for these studies typically include patients who completed treatment lasting a specified time interval. There is undoubtedly no perfect solution. Having said that, allowing more time for QCDRs to study measure adoption, including the time intervals associated with outcome (follow-up measures) and how they affect provider performance rates, would better ensure that quality measures are not prematurely removed from the program.

Recommendations:

1) Revise how benchmarks are currently established by basing calculations on the number of National Provider Identifiers (NPIs), as opposed to Taxpayer Identification Numbers (TINs) reporting on a measure.
2) Continue to approve the inclusion of new process measures, and retain those that have been previously approved, within QCDRs when the appropriate rationale is made.
3) Adopt a more realistic timeline for measure adoption, such as 5 years, allowing QCDRs some leeway in getting buy-in from registry users to implement specialty measures.

Data Quality and Clinical Data Exchange Objective

Comment: Behavioral health providers including psychologists and neuropsychologists will continue to not be fully able to participate and meet this requirement due to their limited ability to report on the Promoting Interoperability (PI) measure, since they were excluded from funding provided to physicians under the HITECH Act for the 'meaningful use' of electronic health records technology. Behavioral health data is a critical component of public health reporting given the mental health crisis this country is experiencing. Yet without the appropriate infrastructure, timely, complete quality data exchange is compromised.

Recommendation: Provide financial incentives for the adoption of electronic health records for behavioral health providers.

Social Determinants of Health Assessment and Community Health Integration Services

[11] Duncan, B. (2012). The Partners for Change Outcome Management System (PCOMS): The Heart and Soul of Change Project. Canadian Psychology/Psychologie canadienne, 53, 93–104. doi:10.1037/a0027762

[12] Reese, R. J., Duncan, B. L., Bohanske, R. T., Owen, J. J., & Minami, T. (2014). Benchmarking outcomes in a public behavioral health setting: Feedback as a quality improvement strategy. *Journal of Consulting and Clinical Psychology*, *82*(4), 731.

[13] Stiles, W. B., Barkham, M., Connell, J., & Mellor-Clark, J. (2008). Responsive regulation of treatment duration in routine practice in United Kingdom primary care settings: Replication in a larger sample. Journal of Consulting and Clinical Psychology, 76, 298 –305. doi:10.1037/0022- 006X.76.2.298

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Social Determinants of Health Risk Assessment (HCPCS Code G0136)

For CY 2026, CMS is proposing to delete HCPCS code G0136; *Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes*), stating that after further review of utilization information, they believe that the resource costs described by HCPCS code G0136 are already accounted for in existing codes. CMS is also proposing to remove this code from the Medicare Telehealth Services list.

CMS is also proposing to make several revisions to the code descriptors for CHI services. Based on feedback received during previous comment periods, CMS is proposing to replace the term "social determinants of health (SDOH)" with the term "upstream driver(s)" as this terminology is more comprehensive and includes a variety of factors that can impact the health of Medicare beneficiaries.

Comment: AACN disagrees with CMS' proposal to delete HCPCS code G0136. We believe that routine assessment of social drivers that are currently performed by other qualified healthcare professionals, such as clinical psychologists, and the associated resource costs are not accounted for in existing codes.

While we understand and respect that CMS' analysis of utilization data resulted in the determination that the resource costs are already accounted for in existing codes, APA Services strongly believes that continued use of this code, reported in conjunction with services other E/M services, would allow providers to:

- systematically assess unmet social needs that are negatively impacting patient health;
- strengthen patient and population health level data gathering initiatives aimed at improving whole-person care;
- develop a care plan to intervene on these unmet social needs;
- reduce variability in screening instruments and increase interoperability of screening responses.

We agree with the proposal to replace the term "social determinants of health (SDOH)" with the term "upstream driver(s)" and agree that this new terminology encompasses a wider range of root causes of the problems that practitioners are addressing through CHI services, such as potential dietary, behavioral, medical, and environmental drivers to lessen the impacts of the problem(s) addressed in the initiating visit.

However, among the other minor revisions made to the code descriptors, was the addition of "E/M" when referring to the initiating visit. AACN respectfully disagrees with and strongly encourages CMS not to adopt this seemingly minor language change. Addition of "E/M" ahead of initiating visit, in both the main descriptor language, and in the first bullet point, would be in direct opposition of clarifications and proposals made by CMS in section II.I, 3. Community Health Integration and Principal Illness Navigation for Behavioral Health.

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Recommendations:

1. AACN strongly encourages CMS to maintain HCPCS code G0136, and to allow for continued use of this service, performed in-person or via telehealth, by eligible behavioral health providers that do not report E/M services.
2. Rename HCPCS code G0136 to Assessment of Upstream Driver(s) of Health
3. Allow all the psychotherapy services (codes 90791-90853) to serve as the initiating visit when furnishing G0136, CHI services and PIN services.

Conclusion

AACN thanks CMS for this opportunity to provide comments on the proposed rule involving changes to payment policy under the 2026 Medicare Physician Fee Schedule. If your staff have any questions, you are welcome to contact AACN President, Dominic Carone at dcaronephd@gmail.com.

Cordially,

Dominic A. Carone, PhD, ABPP

President, American Academy of Clinical Neuropsychology