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September 10, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS 1832-P
P.O. Box 8016
Baltimore, MD 21244-1850

Re: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, File Code CMS 1832-P

Submitted Electronically

Dear Administrator Oz:

The American Academy of Child and Adolescent Psychiatry (AACAP) appreciates the opportunity to comment on the annual Medicare Physician Fee Schedule (PFS) proposed rules for calendar year 2026. AACAP is the professional home to 11,000 child and adolescent psychiatrists, fellows, residents, and medical students, some of whom also treat adults and transitional age youth (ages 18-26 years). Our mission includes promoting the healthy development of children, adolescents, and families. We therefore have an interest in policies and payment issues that affect how psychiatric services are delivered, documented, and paid for, as elements of the regulatory framework in the Medicare program are often adopted by other private payers, Medicaid, and Children's Health Insurance Plans (CHIP). We offer the following comments in the context of continuing workforce shortages for mental and

behavioral health providers, coupled with significant unmet needs for these services for both children and adults.

Medicare Telehealth Services

AACAP is encouraged to see the agency's support of Medicare telehealth services, and we appreciate the emphasis on enabling physicians to use their clinical judgment and expertise concerning when telehealth services are appropriate, taking into account the full clinical picture for their patients. This stance is mentioned throughout the telehealth services section. Psychiatry and mental health services are uniquely well-suited to telehealth visits, and an important modality to help extend a limited workforce, well documented by AACAP's Workforce Maps, which indicate severe shortages of child and adolescent psychiatrists across the country[i]. In addition, psychiatrists have adopted telehealth more than any other specialty, according to an American Medical Association paper published in 2022[ii] since psychiatric services are seamlessly delivered through this modality and contribute to continuity of care.

AACAP appreciates that CMS, for the second year in a row, is not proposing to adopt the Telemedicine Evaluation and Management codes set that became available in Current Procedural Terminology (CPT) in 2025 (CPT 98000-98016). We have already heard from some of our members about the difficulties they are experiencing stemming from adoption of these codes by some health plans, including increased administrative burden and reductions in reimbursement rates.

We are extremely concerned, however, about CMS' proposal to prohibit virtual supervision of residents by teaching physicians outside of rural settings, effectively ending the COVID-era flexibility that helped to ensure continuity of care for patients and ongoing training of residents. In many cases, AACAP members work in large medical groups, including integrated networks of hospitals, with locations in both rural areas and Metropolitan Statistical Areas, and when they teach, the residents are often remote. In these networks, provision of virtual care is often a core strategy which allows patients to receive care when they need it, and where they are located. Teaching physicians are not always physically present at the same location, given the geographic realities of today's medical groups. Ending this policy flexibility would require teaching physicians to drive long distances to be with residents in-person, making the proposal unwieldy and impractical, in addition to removing an access point for mental health services for patients. Many AACAP members both teach and furnish clinical services through the course of their day, and removing the virtual supervision option would prove catastrophic for some of the most vulnerable patients, in addition to interrupting established practice in many resident training programs**. We urge CMS to consider a carve-**

out for teaching physicians where physical examination or procedures can be effectively conducted via telehealth, such as psychiatric services.

Absent from the proposals for 2026 is a renewal of the policy that allows distant site providers to use their practice locations, instead of home addresses, when enrolling as a distant site provider of Medicare telehealth services from home. AACAP has previously expressed significant concern about the use of home addresses on enrollment forms, citing the need for physician safety and privacy. **AACAP respectfully requests an extension of the policy permitting distant site providers to list their practice location instead of their home addresses when enrolling to provide Medicare telehealth services and believes that this policy should be made permanent.**

Efficiency Adjustment

AACAP recognizes that psychiatry is among the few specialties projected to experience an increase (1%) under the Efficiency Adjustment proposal. AACAP welcomes and appreciates the exception of time-based services, E/M visits, care management services, behavioral health services, and services on the CMS telehealth list from the efficiency adjustment and agrees that historically these services have been undervalued. **While these services should be more appropriately valued going forward, the methodology for such a correction should be based on a robust and data-driven approach**. We are concerned that the sweeping approach in the proposed rule will have unintended consequences and could create barriers to medical care, given its negative impact on other medical services.

G2211

AACAP encourages CMS to review and make appropriate adjustments to utilization assumptions regarding the billing of G2211 (visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition). G2211 was initially expected to increase Medicare spending based on estimates that it would be used 38-54% of the time when billing an evaluation and management service, which has not been the case. According to a recent analysis, the code was utilized only 5.2% of the time.[iii] As a result, these assumptions have caused an unwarranted reduction in the Medicare conversion factor due to budget-neutrality requirements and should be reexamined.

Behavioral Health Integration in Advanced Primary Care Management

AACAP appreciates the agency's recognition of the importance of integrating behavioral health into primary care. We agree with the proposed steps to support furnishing the Collaborative Care Model (CoCM) and general Behavioral Health Integration (general BHI) services in practices that are furnishing Advanced Primary Care Management (APCM), via the new add-on HCPCS codes GPCM1 and GPCM2 for CoCM, and GPCM3 for general BHI. We agree with CMS' rationale for these new codes, and the streamlining of billing for these behavioral health services by removing the requirement to track these services by time when they are furnished alongside APCM. **We urge CMS to finalize this proposal**. This will promote greater uptake of CoCM, while also normalizing them as a part of primary care and helping to remove stigma.

Site of Service Differential

AACAP supports CMS' goal of better recognizing the actual cost of physician work in the non-facility setting. **However, we oppose the proposal to reduce indirect practice expense RVUs for all facility-based services which presumes "duplicative payments."** Such a policy risks serious unintended consequences, particularly for patient care in inpatient psychiatric units. An existing shortage of inpatient psychiatric beds could be further worsened should this reduction be applied to these services. This could lead to a reduction in beds or closure of entire units, particularly in rural communities or general hospitals, where access to these services is already a challenge. Downstream impacts would be an increase in visits to the emergency department (ED) and more frequent and prolonged boarding of patients in psychiatric distress in the ED. In a recent report, the Agency for Healthcare Research and Quality found that this longstanding migration of healthcare services to outpatient care has created a mismatch between supply and demand, and has been a key driver in the reduction of available inpatient psychiatric beds, along with the increase in ED boarding, a situation that should not be further exacerbated.[iv]

Request for Information on Prevention and Management of Chronic Disease

AACAP appreciates the agency's interest in whole person care as essential to the management of chronic illnesses and overall health and wellbeing, including mental health, and would like to provide some feedback on one of the questions.

The RFI requests information about motivational interviewing and if the agency should develop separate coding and payment for these services. **Motivational interviewing is a psychotherapeutic technique and is therefore captured in existing psychotherapy codes for both physician and non-physician clinicians and should only be provided by someone appropriately licensed to furnish this intervention**. AACAP is aware that other health and

behavioral health clinicians use motivational interviewing with patients and agrees with CMS that this intervention should be furnished under the general supervision of the billing practitioner, ideally in a physician-led, team-based setting.

We appreciate your consideration of our comments. Should you have questions, please contact Karen Ferguson, Deputy Director of Clinical Practice, at kferguson@aacap.org.

Sincerely,

Tami D. Benton, MD
President

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[i] Workforce Maps by State
[ii] Policy Research Perspectives-Telehealth in 2022: Availability Remains Strong but Accounts for a Small Strong but Accounts for a Small Share of Patient Visits for Most Physicians
[iii] G2211 One Year Later: Adoption, Impact, and What Comes Next
[iv] AHRQ Summit to Address Emergency Department Boarding