ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

September 14, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program [CMS-1848-P]

Dear Dr. Oz:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to share our comments on the Centers for Medicare & Medicaid Services' (CMS's) proposed policies for CY2027 under the Medicare Physician Fee Schedule (PFS).

ABHW is the national voice for health plans managing behavioral health insurance benefits. Our member companies provide coverage to 200 million people in both the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness. Our organization aims to increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes. Furthermore, our policy work aims to ensure that physical and behavioral healthcare is integrated and coordinated. ABHW is committed to improving outcomes in whole-person care for all individuals and communities. We believe access to comprehensive, evidence-based MH and SUD services is critical to enhancing patients' health and overall well-being.

Telehealth

ABHW supports expanding coverage for evidence-based telehealth services and removing unnecessary barriers to the delivery of telehealth care. We appreciate CMS's swift implementation of the telehealth waiver flexibilities in CAA 2026, such as:

- Continuing to waive geographic and originating site restrictions for telehealth services
- Expanding the list of provider types eligible to furnish telehealth services
- Waiving in-person visit requirements for MH services furnished via telehealth
- Creating new modifiers for services delivered via telehealth platforms and for services furnished incident to a physician via telehealth.

We also appreciate CMS's proposal to expand flexibility for teaching physicians to bill for services involving residents with virtual supervision. These flexibilities help alleviate the impact of the nationwide behavioral health workforce shortage, allowing training programs to accept more residents and ensuring they can do so in a financially sustainable way.

Remote Therapeutic Monitoring (RTM)

Since the adoption of distinct RTM codes for Cognitive Behavioral Therapy (CBT), remote monitoring has grown in prominence in the behavioral health field. We are concerned that the proposed restrictions on billing for remote monitoring services would impose additional barriers to technology-enabled care. Remote monitoring services extend the reach of scarce rural clinicians, help patients better manage chronic conditions, and provide greater day-to-day insight into patients' health. We encourage CMS to delay the implementation of these proposed policies to ensure that program integrity and patient access concerns are best addressed.

Software as a Medical Service (SaaMS)

We appreciate CMS's efforts to standardize terminology and improve payment consistency for software-based services. We look forward to working with the agency as it continues to build out its regulatory and payment framework for AI, ensuring that behavioral health tools are properly categorized and subject to necessary oversight.

Adaptive Behavior Codes

The recent increase in Applied Behavior Analysis (ABA) utilization and spending has drawn closer scrutiny to the field. We appreciate CMS's work to promote program integrity in its ABA programs through the publication of its ABA Toolkit, and encourage the agency to codify these recommendations in future rulemaking.

We are concerned about the adoption of codes 97X1X-97X6X, particularly code 97X3X for non–face-to-face services. These services can be more difficult to verify because there may be fewer objective indicators of which service was performed, who performed it, how much time was spent, and whether the activity overlaps with other billed services. This creates heightened risks of insufficient documentation, upcoding, and duplicative or concurrent billing, potentially increasing spending without clear evidence of additional clinical value.

Bundled Payments for SUD Services

ABHW supports CMS's efforts to strengthen SUD services beyond opioid treatment programs (OTPs). Nearly 80 percent of counties in the US do not have an OTP, requiring patients in these areas to travel long distances and increasing the risk of treatment nonadherence. Ensuring robust access to SUD services in office-based settings helps integrate SUD care with patients' primary and specialty care.

Several health plans already use bundled payment models; we encourage CMS to conduct a comprehensive survey of these models to determine how best to support Medicare beneficiaries. Existing models seek to incorporate core SUD services with additional MH, case management, and chronic condition services. Given the unique

geographic and demographic health needs of different communities, ABHW encourages CMS to adopt a flexible approach to bundled payments for SUD services by testing multiple models.

ABHW also supports further evaluation of additional coding to describe ASAM 1.7 care. We agree with the assessment that existing HCPCS codes G2086-G2088 best describe Level 1.5 (outpatient therapy) care. Many patients receiving medications for opioid use disorder have increased complexity and intensity of care needs, and we support efforts to ensure that coding for these services best reflects that.

Shared Medical Appointments

We appreciate CMS's support for voluntary shared medical appointments and the proposal to create a new HCPCS code GSMAS to recognize and pay for them separately. The shared medical appointments model has been used since the 1970s to improve patient engagement, pioneered by the Cleveland Clinic and the Veterans Affairs Administration. While uptake has been limited, we do not believe that a lack of dedicated coding is the primary reason, as CMS notes that existing E/M codes have been used as a stand-in. We are hopeful that creating a dedicated code will provide greater insight into where and how these services are being used. We also support the proposed documentation and consent requirements for these services.

ABHW has been a strong advocate for integrating peer support specialists within behavioral health services, and we appreciate CMS' recognition of peer support as an important component of shared appointments. We are concerned that the term "peer support" in the code descriptor blurs the distinction between the contributions of a peer support specialist within a multidisciplinary medical service and peer support as a distinct practice. Peer support is a distinct, nonclinical practice grounded in lived experience, mutuality, self-determination, and voluntary engagement. It should not be used as a general term for supportive interaction among patients participating in a clinically led group medical service. The term "peer support" should be removed from the proposed HCPCS code GSMAS descriptor and associated valuation language.

Psychiatric Collaborative Care Model (COCM)

ABHW supports the proposed refinements to COCM codes 99492, 99493, 99494, and G2214 and add-on codes G0568 and G0569. We agree with CMS's desire to improve behavioral health integration with primary care and welcome these refinements to work with Relative Value Units and direct Practice Expense inputs. These refinements do not address all the barriers to COCM adoption, though. To further incentivize the use of these services and improve behavioral health integration, we encourage CMS to address longstanding administrative barriers, particularly regarding billing for COCM. Currently, the administrative burden of billing is placed on primary care, which must contract with and manage payments to the behavioral health provider. Creating a mechanism that allows the behavioral health provider to bill directly for their services would reduce the paperwork burden on COCM and incentivize greater uptake.

Smoking and Tobacco Cessation Services, Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services

ABHW appreciates CMS's support for smoking and tobacco cessation and SBIRT services. These services are important tools in improving patient health and reducing the risk of serious conditions like lung cancer, heart disease, and diabetes. We encourage the agency to establish clear expectations regarding documentation and the components required for counseling services.

Additional Actions to Improve Access to Mental Health Services

We continue to urge CMS to take further action in its billing and supervision requirements to expand access to Medicare-covered behavioral health services. A June 2025 report by the Department of Health and Human Services Office of the Inspector General found Medicare beneficiaries seeking behavioral health services face a range of challenges in accessing care due to a shortage of providers and the limited capacity of those providers to accept new Medicare patients.[1]

Although Congress and CMS have acted in recent years to expand access to MH services in Medicare by covering marriage and family therapist (MFT) and mental health counselor (MHC) services and establishing principal illness navigation and community health integration services, treatment rates for people with Medicare remain low. The impact of these changes to close gaps in access to care is limited by the ability of these provider types to supervise other practitioners. Under current regulations, MFTs and MHCs, as well as licensed clinical social workers (LCSWs), are not permitted to provide general or direct supervision to auxiliary personnel, including other MFTs, MHCs, and LCSWs, as well as associates-in-training and students who are training to become licensed under these specialties. These restrictions on supervision create barriers for MFTs, MHCs, and LCSWs to make behavioral health services more accessible to the Medicare population and to train the next generation of the behavioral health workforce.

Mental health associates qualify as auxiliary personnel allowed to bill for services "incident-to" a physician or other non-physician provider (NPP) who is directly supervising the trainee. However, Medicare currently limits NPPs to physician assistants, nurse practitioners, certified nurse-midwives, and clinical nurse specialists. State laws anticipate that master's-level MH clinicians will be supervised by fellow master's-level clinicians when completing state licensing requirements. Thus, licensed mental health therapists cannot supervise treatment provided to Medicare members by unlicensed associates-in-training, despite state expectations that they will do so for all other patients.

In addition, current Medicare regulations also require direct, rather than general, supervision of associates-in-training, further limiting the growth of training programs. Requiring direct supervision unnecessarily constrains service delivery capacity in a field that is already short on providers. Direct supervision limits the capabilities of already licensed clinicians to see their own patients because they must be immediately available

[1] HHS Office of Inspector General, Availability of Surveyed Behavioral Health Providers to Treat New Patients Enrolled In Medicare and Medicaid (June 2025), available at https://oig.hhs.gov/reports/all/2025/availability-ofsurveyed-behavioral-health-providers-to-treat-new-patients-enrolled-in-medicare-and-medicaid/.

to intervene. This limits licensed clinicians' willingness to take on associates-in-training. Permitting general supervision would allow currently licensed clinicians to see their own patients while overseeing the work of associates, further strengthening the MH workforce, and aligning federal policy with state licensure standards.

To address these barriers, we recommend that CMS allow for greater flexibility around the provision of supervision under incident-to requirements as follows:

- Permit post-master's mental health associates-in-training to provide behavioral health services incident to an MFT, MHC, or LCSW under general, rather than direct, supervision
- Allow incident-to supervision by licensed LCSWs, MFTs, and MHCs over mental health associates-in-training by adding them as NPPs.

Making these changes will meaningfully expand Medicare beneficiaries' access to MH services, allow greater choice, and reduce wait times for care. In addition, these changes will increase the pipeline of MH providers trained to care for older Americans, specifically those trained to care for the Medicare population.

Improving Value-Based Care

ABHW recommends advancing a value-based framework for chronic disease management and prevention that emphasizes accountability through quality measures. A critical component of this framework is the development of prevention-focused cost measures that incentivize the early identification and treatment of MH and SUD conditions.

By embedding prevention into value-based payment design, CMS can drive improvements in population health, reduce avoidable costs associated with untreated behavioral health conditions, and ensure that MH/SUD care is fully integrated into chronic disease management strategies.

Conclusion

ABHW is committed to engaging with CMS and other partners to identify innovative opportunities to improve access to behavioral health for all individuals. If you have questions, please contact Kathryn Cohen at cohen@abhw.org.

Sincerely,

Debbie Witchey, MHA
President and CEO