AMERICAN PSYCHOLOGICAL ASSOCIATION SERVICES, INC.

CMS RFI - Unleashing Prosperity Through Deregulation of the Medicare Program Request for Information with a deadline of June 10, 2025

Topic 1: Streamline Regulatory Requirements

1A. Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program? Character Limit: 10,000

Reducing administrative burdens is critical to increasing psychologist participation in Medicare. The 2024 report by the National Academies of Sciences, Engineering, and Medicine (NASEM)—*Expanding Behavioral Health Care Workforce Participation in Medicare, Medicaid, and Marketplace Plans*, (available at: https://nap.nationalacademies.org/read/27759/chapter/1) —unequivocally identified burdensome administrative demands along with inadequate reimbursement rates as a primary barrier to participation. The report recognized that much of the behavioral health workforce is in small independent practices, which often lack the administrative infrastructure, and that increasing participation will require alleviating administrative and financial impediments. The 2024 APA Practitioner Pulse Survey 2024 (available at https://www.apa.org/pubs/reports/practitioner/2024) found that administrative burdens such as audits and pre-authorization requirements were cited by 62% of psychologists as a reason they were not participating in Medicare Advantage and traditional Medicare. The survey also found that only 36% of surveyed psychologists participated in traditional Medicare and only 26% in Medicare Advantage.

Specific regulatory requirements that could be modified or improved to reduce administrative burdens while upholding patient safety and program integrity include:

- Medical Necessity and Prior Authorizations: We consistently hear from psychologists that the documentation requirements on medical necessity present an excessive burden. Prior authorization requirements, particularly those imposed by Medicare Advantage (MA) plans, are overly burdensome, and can be significantly modified without compromising patient safety or program integrity. Prior authorization for some mental health and substance use disorder services was a requirement in 2022 for plans encompassing nearly all (96%) of Medicare Advantage enrollees. Freed, M., Sroczynski, N., & Neuman, T. (2023, April 28). *Mental health and substance use disorder coverage in Medicare Advantage Plans*. KFF. Available at: https://www.kff.org/mental-health/issue-brief/mental-health-and-substance-use-disorder-coverage-in-medicare-advantage-plans/. Psychologists dedicate substantial amounts of time and resources to obtaining prior authorizations, completing complex forms, submitting detailed clinical justifications, and engaging in multiple phone calls or appeals to obtain approval for medically necessary services. This disrupts care delivery, as a patient in need of immediate treatment may face delays of days or weeks awaiting authorization, exacerbating their symptoms or leading to crisis. This burden heavily impacts solo and small group practices, which

often have limited administrative support staff. The administrative burden of prior authorizations discourages psychologists from participating in or accepting new patients from Medicare and MA networks.

Psychologists report a high frequency of initial denials for medically necessary services, triggering extensive appeals processes. These denials can occur even when the services clearly meet established medical necessity criteria, forcing psychologists to engage in further administrative battles. The appeal process is time-consuming, frustrating, and often requires re-submitting information already provided.

We urge CMS to expand medical necessity criteria for psychotherapy services to allow for the delivery of early intervention and prevention services in both Medicare and Medicaid. Currently, individuals at risk of having a mental disorder but who have not yet met full diagnostic criteria are unable to access behavioral health services, since a diagnosis is needed to meet medical necessity criteria. Expanding the medical necessity criteria to include specific Z codes would allow behavioral health providers to intervene earlier, in many cases preventing the development of a behavioral health disorder.

- Audits. Another major source of frustration among psychologists is the lack of clear and specific guidance on documentation, coverage and billing expectations *prior* to being subjected to an audit. Medicare audits targeting psychologists—including post-payment reviews by Medicare Administrative Contractors (MACs), Medicare Advantage companies and Recovery Audit Contractors (RACs)—are creating a substantial and unnecessary administrative burden.

  Psychologists find these audits to be immensely disruptive and financially threatening. Compiling years of patient records, preparing detailed justifications, and engaging in lengthy appeals processes diverts significant time and resources away from direct patient care. Psychologists frequently report that audits often penalize them based on highly granular technicalities in documentation that do not reflect fraud or abuse. These technical denials create substantial recoupments without any benefit to program integrity or patient safety.

  Psychologists are often "punished" for not meeting expectations that were not explicitly communicated, a problem exacerbated when psychologists are subject to differing requirements between MA plans and MACs. This can lead to recoupments based on criteria that were not transparent at the time-of-service delivery.

- Provider Enrollment and Credentialing: APA Services frequently hears complaints that provider enrollment and credentialing processes for Medicare and Medicare Advantage plans are a significant administrative burden, delaying access to care. The initial enrollment process through the Provider Enrollment, Chain and Ownership System (PECOS) can be time-consuming and confusing, with substantial and often inconsistent documentation requirements. Processing days can range from weeks to months, postponing psychologists' ability to bill Medicare and begin seeing Medicare beneficiaries. After successfully enrolling in traditional Medicare, psychologists must separately credential for *each* MA plan in their service area. The variability in MA plan requirements, forms, and portals further complicates this process.

- Making Remote Site Provider Address Flexibilities Permanent: APA Services strongly urges the permanent adoption of Medicare policy allowing listing of a practice address other than the practitioner's home address as a distant site address for billing for telehealth services. This

would reduce administrative burdens and enhance provider safety without compromising program integrity.

Historically, CMS policy on a telehealth provider's distant site address lacked clarity. The Medicare Claims Processing Manual, Chapter 12, Section 190.6.1 Submission of Telehealth Claims for Distant Site Practitioners, and the MLN Booklet on Telehealth Services indicated that telehealth services claims should be submitted to the contractors processing claims for the practitioner's "service area," without this term being defined. In response to requests for clarification on this topic, CMS stated that practitioners should enter "where they typically practice" on line 32 of the HCFA 1500 claim form, and that this should be their home address if that is their typical practice location.

To support the expansion of telehealth services, CMS has allowed providers rendering telehealth services to list a practice address rather than their personal home address on their Medicare enrollment and billing forms. We applaud CMS for extending this flexibility through CY2025 and strongly urge the Agency to make it permanent, as it would:

- Enhance Provider Safety and Well-being: Workplace violence is a leading cause of job dissatisfaction among providers, contributing to staff turnover, costs for treating injuries, and staff time away from work. Requiring a provider to list their home address on any Medicare form, especially one published on a public facing platform, presents a direct and unacceptable safety risk. Providers should be able to maintain privacy, reducing the potential for harassment or other security concerns.
- Reduce Administrative Burden: A reversal of the current policy would trigger a flurry of Medicare billing and enrollment forms as thousands of providers would be compelled to change their listed address. CMS may lack the capacity to process such a volume efficiently, creating widespread administrative disruptions for both providers and the agency, and delaying patient access to care.
- Align with Modern Practice: As telehealth becomes an increasingly vital mode of healthcare delivery, requiring a home address for distant site billing is an outdated and irrelevant policy. Permitting a designated practice address aligns Medicare policy with modern, remote work arrangements prevalent in healthcare.

- <u>Allow same day billing of assessment, scoring and documentation services and psychotherapy services.</u> Currently, the National Correct Coding Initiative (NCCI) Practitioner Procedure-To-Procedure (PTP) edits related to CPT® code 96127 *(Brief emotional/behavioral assessment with scoring and documentation, per standardized instrument)* prohibit its use by a behavioral health clinician on the same date of service for provision of psychotherapy services. This prohibition is a barrier to implementation of measurement-based care for behavioral health services, which requires the use of standardized, objective instruments to track care and its impact on patient well-being over time.

  The use of measurement-based care has been found to have multiple benefits for both patients and providers by improving communication between patients and providers, increasing shared decision making and enhancing therapeutic relationships, and supporting collaboration across providers. Integrating measurement-based care into behavioral health services is foundational for developing alternative payment models and valued based care for behavioral health. We urge CMS to remove a key barrier to implementing measurement-based care by allowing same day billing of CPT code 96127 and codes for psychotherapy services.

1B. Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers? Character Limit: 10,000

Several aspects of Medicare's quality and data reporting requirements, particularly within the Merit-based incentive Payment System (MIPS), impose significant and often counterproductive administrative burdens on psychologists. These burdens undermine efficient practice and can disincentivize meaningful participation in quality improvement. We recommend the following changes to support psychologists participating in Medicare:

- Transition from MIPS to MIPS Value Pathways: MIPS Value Pathways (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, or 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.
- Provide increased flexibility in Qualified Clinical Data Registry (QCDR) measure development: APA has prioritized the development and implementation of patient-reported outcomes measures (PROS), as it can be challenging to find quality measures for MIPS reporting that are relevant to specific specialties, such as mental and behavioral health. This is, in part, why CMS established qualified clinical data registries (QCDRs) as a way for specialty societies who did not have access to enough quality measures to develop these measures for their members with more flexible development requirements than going through the CMS measures under consideration process. However, over the last several years, CMS has made measure development for QCDRs overly onerous, constantly changing testing requirements with little direction on what those requirements actually are. Further, they have continued to discourage the development and approval of process measures in lieu of favoring outcome measures. However, it has also become clear that there is a clinical need for additional process measures, which are particularly critical to neuropsychologists and providers who conduct psychological assessments as these care models typically involve only one or two meetings with the Medicare beneficiary, with no ongoing relationship. Unfortunately, it has been very challenging to get QCDR process measures approved. We recommend that CMS apply flexibility to programmatic requirements related to QCDR measure development and approve new process measures within QCDRs when appropriately supported by a strong clinical rationale.
- Establish benchmarks based on National Provider Identifiers (NPIs): 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. The unintended consequence of this approach is that eligible clinicians (EC's) are strongly disincentivized from reporting on

specialty measures and instead choose measures they know they can score enough points on to avoid a payment penalty. We recommend establishing quality measure benchmarks by calculating the number of National Provider Identifiers (NPIs) as opposed to Taxpayer Identification Numbers (TINs), having reported on a measure, which would reduce burdens on providers by allowing them to access more meaningful measures and meeting scoring requirements without the fear of a negative payment adjustment.

Other specific administrative processes that are a significant burden to psychologists include:

- Medical Necessity Determinations for Psychotherapy: As mentioned above, medical necessity documentation requirements are frequently identified by psychologists as creating a significant administrative burden for psychologists. This burden is directly tied to the need to justify the rationale for the frequency and duration of sessions.

  A pervasive concern among psychologists relates to the differential treatment of psychotherapy codes, particularly the 90837 (60-minute psychotherapy) code versus the 90834 (45-minute psychotherapy) code. We hear frequent reports of 60-minute sessions being subjected to intense scrutiny, denials, or even recoupments. Numerous psychologists have reported experiencing denials for 90837 codes that are clinically appropriate and properly billed, even when proper documentation supports the need for the 60-minute session. Psychologists have even reported receiving direct instructions or implications from payers or auditors that the 90837 code should be avoided, or that they "cannot" see patients for this code.

  This challenging of psychologists' appropriate use of longer therapy sessions creates a heavy administrative burden through the constant need to defend clinically sound treatment decisions. This undue scrutiny and the resulting administrative demands for longer, often more intensive, psychotherapy sessions are a significant disincentive for psychologists to participate in Medicare and Medicare Advantage networks. It forces providers to either compromise their clinical judgment by shortening sessions or absorb the financial and administrative costs of denials and appeals. This ultimately limits beneficiaries' access to clinically appropriate mental health care, especially for those requiring more complex or in-depth therapeutic interventions.

- Post-payment reviews, audits, and clawbacks: Psychologists often find that the specific documentation standards or medical necessity criteria that lead to recoupments were not clearly communicated or consistently applied by reviewers at the time the services were provided. This lack of clarity and inconsistent application by reviewers directly contributes to the significant and financially destabilizing administrative burdens faced by psychologists participating in Medicare and Medicare Advantage programs, particularly in the form of Post-payment reviews, audits, and clawbacks. This burden arises from the ability of Medicare contractors and Medicare Advantage plans to retroactively clawback payments for services provided months, and sometimes even years, after those services were rendered and the associated costs (e.g., clinician time, overhead) have been incurred. Psychologists frequently report that these recoupments are often based on highly granular "technicalities" in documentation or coding interpretations, rather than direct concerns about the clinical appropriateness or quality of the psychological care delivered. Responding to post-payment review requests and engaging in lengthy appeals processes demands an extraordinary amount of administrative time and resources. Psychologists are

forced to divert valuable time away from patient care to compile records, write detailed rebuttals, and participate in calls, without any compensation for this non-clinical work.

The pervasive threat of these retroactive payment adjustments and the associated administrative and financial strain significantly discourage psychologists from joining or maintaining participation in Medicare and Medicare Advantage networks. This reality has been consistently highlighted by various surveys; for instance, the APA 2024 Practitioner Pulse survey identified these types of payment insecurities as a critical factor influencing psychologists' decisions regarding participation in insurance networks, including Medicare Advantage. This reluctance directly exacerbates existing access-to-care challenges for Medicare beneficiaries seeking mental health services.

- Provider enrollment and credentialling. Provider enrollment and credentialling is another significant burden cited by psychologists and is highlighted in section 1A above.

1C. Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and other providers? Character Limit: 10,000

APA Services believes that significant opportunities exist to reduce the frequency and complexity of reporting for psychologists within the Medicare program, particularly by reforming prior authorization processes. As mentioned above, many services, including common psychotherapy codes, are subjected to routine prior authorization, regardless of established clinical necessity or the provider's track record. Medicare, in collaboration with Medicare Advantage (MA) plans, should leverage robust data analytics to identify specific services, provider types, or patient populations for which prior authorization rarely results in a denial or a change in care plan. For these identified services, prior authorization requirements could be significantly reduced or eliminated. By collaborating with mental health experts to define clear criteria for services that *do* require prior authorization, CMS can narrow the scope of services subject to reporting, focusing on oversight where it is truly needed. *See* National Academies of Sciences, Engineering, and Medicine. 2024. Expanding Behavioral Health Care Workforce Participation in Medicare, Medicaid, and Marketplace Plans. Washington, DC: The National Academies Press. https://doi.org/10.17226/27759.

In addition, a major source of complexity and frustration for psychologists is the lack of clear, consistent, and easily accessible information regarding prior authorization requirements. Psychologists often face varying rules across different MA plans, struggle to locate specific clinical criteria used for approval, and are left to infer the rationale behind certain authorization demands. This ambiguity leads to trial and error in reporting, increased denials, and time-consuming appeals. Medicare and MA plans should proactively communicate all prior authorization requirements, the specific clinical criteria used for approval, and the underlying rationale for those criteria in a transparent and accessible manner. This communication should be readily available through standardized online portals, clear policy documents, and comprehensive provider manuals. This transparency would lead to fewer unnecessary submissions, fewer denials based on insufficient information, and a reduction in time spent on administrative inquiries and appeals. It also empowers patients to understand the process. *See* National Academies of Sciences, Engineering, and Medicine. 2024. Expanding Behavioral Health Care Workforce Participation in Medicare, Medicaid, and Marketplace Plans. Washington, DC: The National Academies Press. https://doi.org/10.17226/27759.

Streamlining processes can allow more time for direct patient care. Simpler rules mean more providers are willing to accept Medicare, leading to better access to needed mental health services for beneficiaries.

Topic 2: Opportunities to Reduce Burden of Reporting and Documentation

2A. What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity? Character Limit: 10,000

APA Services believes that significant changes can be made to simplify Medicare reporting and documentation requirements, particularly for psychologists, without compromising patient safety or the integrity of the Medicare program. Psychologists consistently highlight that current practices impose undue administrative burdens that could be alleviated through targeted reforms.

APA Services proposes simplification through two primary avenues:

- Standardizing and Simplifying Documentation for Medical Necessity: Psychologists currently face an expectation for highly detailed and often redundant narratives in progress notes to continuously demonstrate medical necessity. This approach is perceived as primarily serving audit defense rather than patient care. CMS could issue comprehensive guidance to standardize and significantly simplify documentation requirements, especially as they relate to medical necessity for ongoing psychological services.
- Emphasizing Education over Punitive Measures in Audits: Psychologistssrequently report that Medicare audits often feel like a "gotcha" approach, particularly for first-time or minor documentation errors. The lack of clear, consistent communication regarding precise documentation requirements, followed by severe financial penalties (e.g., clawbacks), creates significant anxiety and discourages participation in Medicare and Medicare Advantage networks. To address this, CMS should direct Medicare Administrative Contractors (MACs), MA companies, and Recovery Audit Contractors (RACs) to adopt more educational and transparent practices. Specifically:
    - Prioritize “educate first” for Minor Discrepancies: MACs, MA companies, and RACs should be mandated to adopt an "educate first" model for minor or first-time documentation discrepancies. Instead of immediate and substantial recoupments, the initial response to identified non-compliance should focus on providing constructive, educational guidance aimed at correcting future practice.
    - Provide proactive and clear guidance: MACs, MA Companies, and RACs should provide much clearer, proactive guidance on what specific elements auditors are looking for to demonstrate medical necessity, particularly for psychological services. This should include concrete examples of compliant documentation for various clinical scenarios and CPT codes, to ensure psychologists are fully aware of expectations *before* services are rendered and audited.
    - Communicate Specific Audit Reason: If an audit is initiated, MACs, MA companies, and RACs should be required to clearly communicate the specific reasons for the audit. This means detailing the exact requirements that are under scrutiny, offering actionable feedback, and avoiding broad, generalized statements (e.g., "billing patterns"). This

transparency allows psychologists to understand the issue and focus their response effectively.

- Reserve Punitive Measures for Serious Issues: Auditors should reserve punitive measures, such as significant recoupments or sanctions, for patterns of clear fraud, egregious errors, or repeated non-compliance after educational interventions have been provided. For minor or technical documentation issues, the initial response should be educational guidance aimed at correcting future practice.

This comprehensive approach would foster a collaborative environment, enabling providers to understand and meet expectations without the fear of disproportionate penalties for unintentional errors. Program integrity is strengthened by promoting sustained compliance through better understanding and education, rather than by creating an adversarial relationship that discourages provider participation. By simplifying documentation expectations and reforming audit practices, CMS can significantly reduce administrative strain, promote sustained compliance through better understanding, and ensure higher quality documentation across the board, all while maintaining robust program integrity.

2B. Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers? Character Limit: 10,000

CMS can significantly reduce the frequency and complexity of reporting for psychologists by reforming prior authorization processes, particularly within Medicare Advantage (MA) plans. Medicare Advantage plans, in particular, often require frequent prior authorizations and concurrent reviews for mental health services. Psychologists consistently highlight prior authorizations as a major source of administrative drain, impacting both their capacity to provide care and patients' ability to access it seamlessly. The current model often necessitates repetitive authorization requests, even for patients with chronic conditions or those engaged in long-term, medically necessary therapy. CMS could implement rules to reduce the frequency of prior authorization requirements for established patients receiving ongoing, evidence-based mental health care, especially after an initial authorization period. This would directly decrease the sheer volume and frequency of authorization submissions, thereby reducing reporting complexity. In addition, for providers with a documented history of low denial rates and strong clinical outcomes, CMS and MA plans should offer a 'trusted provider' status that exempts them from routine prior authorizations. This concept, often referred to as "gold carding," represents a pragmatic and effective mechanism to streamline process without compromising patient safety or program integrity and is supported by organizations like the National Academies of Sciences, Engineering, and Medicine (*See e.g. Recommendations suggested in* National Academies of Sciences, Engineering, and Medicine. 2024. Expanding Behavioral Health Care Workforce Participation in Medicare, Medicaid, and Marketplace Plans. Washington, DC: The National Academies Press. https://doi.org/10.17226/27759) and the AMA (see e.g., AMA. 2024. Prior authorization reform initiatives. https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-reform-initiatives).

2C. Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number. (Note: The OMB Control Number consists of two groups of four digits joined by a hyphen and it generally appears on the top right of the first page of a Medicare form and the CMS form number generally appears on the bottom left of the page of a Medicare form.) Character Limit: 10,000

The initial enrollment process and subsequent revalidation for Medicare billing privileges is a set of documentation and reporting requirements that have been cited by psychologists as significantly overly

complex and redundant. Psychologists requently report that the process of becoming a Medicare provider, and maintaining that status, is characterized by lengthy delays. The Medicare Enrollment Application for Physician and Non-Physician Practitioners (CMS-855I), with OMB Control Number: 0938-1355, is the primary instrument for initial enrollment. While an online system (PECOS) exists, the application itself is extensive, requiring a substantial amount of detailed personal, professional, and practice-related information and the PECOS system was not intuitive and there were numerous confusing steps including difficulty logging in. In addition, the processing times for these applications can be long, ranging from several weeks to many months. During this period, the psychologist is unable to bill Medicare for services, creating an immediate barrier to care for Medicare beneficiaries seeking their services. Beyond Medicare FFS enrollment, psychologists must undergo separate and distinct credentialing processes for *each* individual Medicare Advantage plan they wish to join. This further layers complexity, as each MA plan often requires its own application, verification procedures, and review timelines, again frequently requesting information already provided to Medicare FFS. This is a crucial area of redundancy that significantly disincentives MA network participation.

These lengthy, complex, and duplicative enrollment and revalidation processes serve as substantial administrative barriers for psychologists often leading to delayed access to care and reduced provider participation. By simplifying and modernizing the initial enrollment and revalidation processes for Medicare (e.g., CMS-855I, OMB Control Number: 0938-1355) and implementing mechanisms for streamlined credentialing with Medicare Advantage plans that leverage existing data from state licensure boards and other federal sources, CMS can significantly reduce administrative burden without compromising program integrity.

Topic 3: Identification of Duplicative Requirements

3A. Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or with other healthcare programs (including Medicaid, private insurance, and state or local requirements)? Character Limit: 10,000

APA Services strongly encourages CMS to do all that it can to standardize administrative processes across traditional Medicare, Medicare Advantage (MA) plans, and state Medicaid programs. This would substantially reduce the burden created by duplicative and inconsistent requirements across these programs. Psychologists consistently highlight this fragmentation as a major administrative hurdle.

The current landscape forces psychologists to navigate a convoluted patchwork of varying requirements for essentially the same services. In particular, MA plans frequently impose their own distinct prior authorization, concurrent review, and appeals processes that are layered on top of, and often differ significantly from, Traditional Medicare rules. This creates an administrative labyrinth where psychologists must understand and adhere to a multitude of varying procedures depending on the specific MA plan a patient is enrolled in. The variability extends to practical operational details: psychologists must contend with different online portals for submission, unique proprietary forms (without a single "Medicare" form number or OMB Control Number to streamline their use), and diverse clinical review criteria that can vary widely from one MA plan to another, even for identical services. This means a psychologist providing care to patients across multiple MA plans faces exponential increases in administrative effort.

Beyond the internal Medicare ecosystem, psychologists often find themselves encountering similar duplicative requirements when interacting with state Medicaid programs and commercial insurance plans. Each payer may demand unique documentation formats, submission methods for claims and prior authorizations, and specific reporting metrics that do not seamlessly integrate with other systems. This creates a significant "relearning" curve and ongoing administrative burden for practices that serve a diverse patient population.

The sheer complexity and variability increase the likelihood of administrative errors, leading to claim denials and subsequent, time-consuming appeals processes, even for medically necessary services. The frustration and financial risk associated with navigating these fragmented systems act as a significant disincentive for psychologists to participate broadly in Medicare Advantage networks or to expand their Medicare caseloads, thereby limiting access to mental health care for beneficiaries.

Overall, APA Services regularly receives feedback from psychologists highlighting several key areas where duplicative Medicare requirements, both internal to the program and in relation to other payers, create substantial and unnecessary administrative burdens. These redundancies impede efficient practice and ultimately limit patient access to mental health care. The most prominent areas of duplication include:

- Medical Necessity Documentation: While the fundamental principle of documenting medical necessity is universal across all payers, the *specific format, level of detail, and terminology* expected for psychological services vary significantly. This forces psychologists to meticulously adapt their clinical documentation to satisfy the unique and often nuanced demands of Medicare Fee-for-Service (FFS), diverse Medicare Advantage (MA) plans, distinct state Medicaid programs, and numerous private insurers. This leads to substantial inefficiencies, promotes defensive documentation driven by compliance rather than pure clinical need, and significantly increases administrative burdens.
- Prior Authorization Processes: Psychologists treating patients covered by different plans face a fragmented and complex prior authorization environment. Each Medicare Advantage plan, state Medicaid managed care organization, and private insurer typically operates with its own unique prior authorization forms, dedicated online portals, specific phone numbers, and often proprietary clinical review criteria. This lack of standardization consumes substantial administrative time as practices must manage multiple, disparate systems for similar authorization requests, thereby creating delays in access to care.
- Provider credentialling and Enrollment: The credentialing and enrollment process is profoundly redundant across the healthcare system. Psychologists must credential with each individual Medicare Advantage plans after enrolling with Medicare FFS. This is in addition to credentialing for state licensure, Medicaid programs, and various private insurance panels. Much of the demographic, licensure, and malpractice information requested across these applications is redundant and repeatedly submitted. This process creates significant upfront administrative hurdles for new providers, delaying their ability to see patients, and represents an ongoing administrative burden for existing practices managing multiple payer relationships
- Auditing and Compliance Monitoring: Providers can be subject to multiple, overlapping audits from various entities. Psychologists can face audits from Medicare FFS, individual Medicare Advantage plans, state Medicaid agencies, and even private payers, often reviewing the same patient records or service types but with different criteria,

methodologies, and timelines. This creates immense stress, consumes vast administrative resources, and leads to inconsistent findings.

CMS should lead efforts to establish and enforce a consistent set of evidence-based clinical criteria for prior authorization and utilization review across Traditional Medicare and all Medicare Advantage plans. This would reduce arbitrary variability and ensure that reviews are based on consistent, clinically appropriate standards. In addition, CMS should encourage or mandate the use of standardized forms and submissions for common administrative tasks (e.g. prior authorization, credentialing updates, etc.) across all Medicare programs. CMS should also consider actively collaborating with state Medicaid agencies and major commercial payers to identify and align on common administrative practices and reporting requirements for mental health services, reducing the overall burden across the healthcare system.

By addressing these pervasive duplicative requirements, Medicare can significantly streamline administrative processes, enhance practice efficiency for psychologists, and ultimately improve the accessibility and continuity of essential mental health services for beneficiaries, all while maintaining robust program oversight.

3B. How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring? Character Limit: 10,000

APA Services strongly advocates for enhanced cross-agency collaboration to significantly reduce the duplicative efforts that currently burden psychologists in auditing, reporting, and compliance monitoring across various healthcare programs. Psychologists spend considerable time navigating disparate systems, which could be streamlined through a unified approach. To achieve this, APA Services proposes the following avenues for enhanced cross-agency collaboration:

- Develop Harmonized Documentation Standards: Psychologists currently face redundant efforts in documentation due to the varying specific formats, levels of detail, and terminology expected by different payers, including Medicare Fee-for-Service (FFS), Medicare Advantage (MA) plans, state Medicaid agencies, and private insurers. This forces providers to meticulously tailor documentation to specific payer requirements, even for similar services. CMS, in collaboration with other federal agencies (e.g., SAMHSA, HRSA, etc.), state Medicaid agencies, and even potentially private payer representatives (like those who have MA plans), could develop common, high-level documentation standards for mental health services that are clinically relevant while also allowing for a degree of flexibility. This could reduce the need for providers to tailor documentation to specific payer whims, promoting consistency and potentially reducing audit risk stemming from inconsistent documentation.
- Disseminate Joint Guidance and Training Materials: Providers currently face confusion and duplicative effort in understanding and complying with multi-payer expectations for billing, documentation, and compliance. Different agencies and payers often provide their own, sometimes conflicting, guidance. CMS, along with other federal and state agencies, could develop and disseminate joint guidance or training materials for providers on common billing, documentation, and compliance requirements for mental health services across programs. This collaborative approach to education could significantly reduce confusion, improve provider understanding of multi-payer expectations, and lead to more consistent compliance across the board, thereby reducing duplicative administrative efforts in learning and adhering to varied rules.

By enhancing cross-agency collaboration in areas such as documentation standards and provider education, CMS can reduce duplicative efforts in reporting and compliance monitoring. This will free up valuable provider time and resources, allowing them to focus more on direct patient care while maintaining robust program oversight across the healthcare system.

3C. How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems? Character Limit: 10,000

There are several ways APA Services believes that Medicare can be improved in this direction, including:

- Increase Transparency: A critical opportunity to align MA plans with best practices is in requiring greater transparency concerning mental health and substance use disorder services. Current MA plan practices often fall short of industry best practices by lacking transparency in:
    - Prior Authorization Criteria: Providers and beneficiaries frequently encounter unclear or inaccessible criteria for prior authorization of mental health and substance use disorder services, leading to confusion and unnecessary administrative effort;
    - Denial Rates and Processing Times: There is insufficient public reporting on denial rates for mental health and substance use disorder services, as well as average processing times for prior authorization and appeals. This opacity prevents a comprehensive understanding of access barriers;
    - Provider Network Adequacy: The true adequacy of mental health provider networks within MA plans often lacks clear, granular transparency, making it difficult for beneficiaries to assess true access to care.

  To align with modern best practices in healthcare transparency and consumer protection, CMS should mandate greater transparency for MA plans regarding their mental health prior authorization and appeal processes. This should include:
    - Public reporting of denial rates for mental health and substance use disorder services, broken down by specific service type and reason for denial;
    - Public reporting of average processing times for prior authorization requests and appeals related to mental health and substance use disorder services;
    - Requiring MA plans to publish all prior authorization criteria in a clear, consistent, and easily accessible format for both providers and beneficiaries, aligning with state efforts to increase MA plan transparency.

  These changes would help providers and beneficiaries make more informed choices, fostering greater accountability among MA organizations without imposing additional new regulatory requirements on providers.

- Continue telehealth flexibilities: APA Services urges CMS to continue current Medicare telehealth flexibilities to sustain access to mental health care. Critical aspects of how psychologists deliver care remain subject to temporary flexibilities that are set to expire. This regulatory uncertainty regarding telehealth flexibilities hinders practices' ability to plan effectively for continuity of patient care.

  Flexibilities in effect through September 30, 2025 include:
    - Waiving originating and geographic sites
    - Audio-only coverage

- Allowing Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to serve as distant sites - Critical for maintaining access in underserved communities.
- Temporary waiver of telemental health in-person requirement
- Continuation of Acute Hospital Care at Home Program

APA asks CMS to work with Congress to make permanent or extend these vital flexibilities for as long as possible before the end of September. The impending expiration threatens to disrupt established care patterns that have proven effective since their implementation. In particular, without the temporary waiver of telemental health in-person requirement, the requirement for in-person visits within 6 months of initiating telehealth services and annually thereafter would create substantial barriers for patients with mobility issues, transportation challenges, or those in underserved areas. Subsequently, it is critical that CMS release implementing guidance as soon as possible to minimize confusion among providers.

- Address Outdated Medicaid In-State Location Requirements: APA Services recommends that CMS provide guidance to address outdated Medicaid in-state location requirements which hinder access to behavioral health care.

  Some state Medicaid policies require licensed providers to have an in-state service address to be considered an "in-state provider," even if they hold a valid in-state license. Practicing across state lines is common today, and state Medicaid telehealth policies have yet to keep pace. As a result, psychologists are often denied enrollment by state Medicaid agencies or are required to adhere to onerous and unnecessary out-of-state provider enrollment rules, despite being duly licensed in the state. While CMS and state Medicaid programs have updated requirements to allow distant site providers to furnish telehealth services, "brick-and-mortar" service address requirements remain. States should ensure that so long as a health care provider is appropriately licensed by the state's licensing Board, they should be treated as an in -state provider.

  We ask CMS to update prior telehealth guidance to states to better communicate provider enrollment requirements under current law, identify where states have authority to modernize their policies, and provide recommendations for harmonizing enrollment requirements.

- Improve Digital Behavioral Health Treatment (DMHT): We commend CMS for finalizing the creation of new G codes for DMHT devices furnished incident to professional behavioral health services used in conjunction with ongoing behavioral health care treatment under a behavioral health treatment plan of care. However, we encourage CMS to expand the G0552 code to include devices that treat physical conditions utilizing psychological interventions, as well as many others that do not meet current device classification requirements. Importantly, economic studies have shown the potential for DMHT devices to decrease overall medical spending. A variety of DMHT devices are available that are specific to a mental disorder (e.g. major depressive disorder and PTSD) or that target physical conditions by addressing the mental health component (e.g. chronic pain, anxiety and irritable bowel syndrome), but only some of these meet G0552 requirements.

  As we noted in our response to the CY 2025 proposed Medicare Physician Fee Schedule, we believe requiring clearance under 21 CFR 882.5801 is unduly narrow. This regulation, originally intended as a catch-all for computerized behavioral therapy devices, does not encompass the current diversity of products that could be used as DMHT devices. FDA has since established

regulatory classifications tailored to different device types or indications for use, and the agency is likely to create new categories as technology and treatment modalities evolve.

CMS should allow use of devices cleared by the FDA as meeting their requirements for safety, efficacy, and quality systems controls, and that are appropriate for use as a part of a behavioral health therapy plan. This would include: Computerized Behavioral Therapy for the Treatment of Fibromyalgia Symptoms (21 CFR 882.5804); Computerized Behavioral Therapy Device for Treating Symptoms of Gastrointestinal Conditions (21 CFR 876.5960); Digital Therapeutic So□ware for Attention Deficit Hyperactivity Disorder (21 CFR 882.5803); and Digital Therapy Device to Reduce Sleep Disturbance for Psychiatric Conditions (e.g., nightmare disorder, PTSD, etc.) (21 CFR 882.5705). Additional regulatory device classifications issued by FDA under these regulations for other digital behavioral therapies should also qualify for payment under G0552 as they come to market.

We recommend that any digital cognitive behavioral therapy that is cleared or approved under section 510(k), 513(f)(2), or 515 of the Federal Food, Drug, and Cosmetic Act be eligible for payment under these codes if they meet the following criteria:

- Are cognitive behavioral therapy or are treatment for behavioral health conditions;
- Include special controls from FDA requiring clinical evidence to demonstrate safety & efficacy;
- Do not include a hardware device (other than a patient's own phone/computer).

We encourage CMS to establish a national payment rate for G0552, and to clarify that G0552 can be furnished via telehealth or add the code to the telehealth list to ensure that practitioners who are permitted to offer DMHTs to appropriate patients may do so remotely. The new DMHT code describes an inherently remote service, in which the patient receives access to the DMHT from their practitioner for use in the patient's home. Given the manner in which the diagnosis and on-going psychotherapy services are currently furnished, G0552 was not conceived as requiring in-person delivery.

Finally, we urge CMS to issue guidance to Medicare Administrative Contractors (MACs) requiring coverage of new DMHT codes, and instructing MACs to develop a timely and transparent process for G0552 device claims reviews. The delay by MACs in establishing reimbursement for G0552 is limiting access to these new devices, limiting Medicare patient access to effective treatments.

- Optimize Safety Planning Interventions (SPI). CMS should allow trained clinical staff to provide Safety Planning Interventions and Post-Discharge Telephonic Follow-Up Contacts 'incident to' the licensed billing provider. As we commented in responding to the CY2025 Medicare fee schedule proposed rule, we believe there is sufficient evidence to support trained clinical staff meeting the definition of auxiliary personnel under 42 CFR 410.26(a)(1) or who are employed by a hospital to furnish these services under the supervision of the billing practitioner. Restricting the service to billing practitioners personally providing the service would limit access to an often life-saving service.

- Eliminate Cost-sharing requirements for Integrated care. Integrated primary and behavioral health care models hold tremendous promise for improving patient outcomes for both behavioral and general medical conditions, increasing access to behavioral health treatment, and reducing overall health care costs. CMS should align with best practices within integrated care delivery systems by eliminating patient cost-sharing requirements for integrated care services billed using behavioral health integration (BHI) codes (99484, 99492, 99493, 99494, G0323, G2214), as well as for

interprofessional consultation (99446-99449, 99451). Requiring cost-sharing disincentivizes delivery of integrated care. Because BHI codes are billed for providers' collaboration without the patient present, cost-sharing can reduce patients' interest in receiving integrated care.

Topic 4: Additional Recommendations

4A. We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program. Character Limit: 10,000

APA Services offers several additional recommendations for deregulating and reducing administrative burdens within the Medicare program, which would concurrently enhance access to mental health care for beneficiaries.

- Reimburse for Services of Advance Psychology Trainees: We urge CMS to direct Medicare Administrative Carriers and state Medicaid programs to reimburse for services provided by advanced psychology trainees under the supervision of a Medicare- or Medicaid-participating psychologist. These advanced trainees have completed all doctoral-level coursework, passed comprehensive examinations, and are completing their required clinical internship as the final phase of their doctoral training before licensure. This change would alleviate administrative pressure on the existing psychology workforce by expanding the pool of supervised providers, thereby increasing access to care. Currently, 29 state Medicaid programs provide at least some coverage of services provided by advanced psychology trainees who have completed all coursework and are in an approved internship. Requiring Medicare carriers and Medicaid programs to cover supervised psychology trainee services would help support the psychology workforce pipeline, using the same policy in place to increase access to supervised services provided by medical residents in primary care. Private sector plans are also beginning to provide coverage of advanced psychology trainee services, and Blue Cross Blue Shield of Oklahoma (which covers OK, TX, NM, IL, and MT) recently announced it will join Optum, Aetna, and Cigna/Evernorth in approving reimbursement for these services. We urge CMS to standardize coverage of advanced psychology trainees by directing Medicare Administrative Carriers and state Medicaid programs to reimburse for their services when provided under the supervision of, and are billed by, licensed Medicare or Medicaid-participating psychologists.
- Update CMS Policy on Evaluation & Management (E/M) Codes for Psychologists with Prescription Privileges: Some psychologists have prescriptive authority, meaning they are legally authorized to prescribe medications for the treatment or management of mental and behavioral health conditions. Qualified prescribing psychologists are eligible to prescribe medications in the Department of Defense, Public Health Service, and Indian Health Service, and some states also allow prescribing. Increasing Medicare participation of clinical psychologists with prescriptive authority will increase access to psychiatric medication management. Psychologists with prescriptive authority are in great demand, but they can only work to the full extent of their scope of practice by reporting and being reimbursed for evaluation and management (E/M) services for medication management when treating patients covered by private insurance, Medicaid, or Medicare Advantage plans. Traditional fee-for-service Medicare does not recognize legally authorized and state-licensed prescribing psychologists as eligible to report E/M services when performing medication management. Consequently, prescribing psychologists with years of experience cannot prescribe or adjust medication for Medicare beneficiaries. Patients receiving treatment from a prescribing psychologist through their commercial health care

coverage, face losing access to their prescribing psychologist once they transition to Medicare coverage because of Medicare's failure to recognize prescribing psychologists who meet state prescriptive authority requirements.

This contradicts CMS' intent to ensure all healthcare providers can practice to the full extent of their licensure. It also prevents Medicare beneficiaries from accessing all the services that prescribing psychologists are legally able to provide; in Louisiana, prescribing psychologists working in FQHCs use E/M when providing medication management and are reimbursed by all payers except traditional Medicare. Qualified prescribing psychologists are eligible to prescribe medications for the treatment or management of mental and behavioral health conditions in the Department of Defense, Public Health Service, and Indian Health Service. CMS should revise internal policies to recognize clinical psychologists with prescriptive authority credentials and allow them to report and be reimbursed for E/M services when operating fully within their scope of practice to furnish medication management to Medicare beneficiaries.

- Update CMS policy to expand the range of covered providers for Intensive Behavioral Therapy (IBT) for obesity in both Medicare and Medicaid. APA Services and the Obesity Care Advocacy Network (OCAN) recently requested a formal reconsideration of the 2011 National Coverage Determination for Intensive Behavioral Therapy (IBT) for Obesity (210.12) (the "2011 NCD" or the "2011 NCD for Obesity") to modify the limitations of this service that are not aligned with current evidence (limiting coverage to IBT services delivered by primary care providers in a primary care setting.) CMS can increase access to effective treatment for this chronic condition by allowing specialty physicians, nurse practitioners, clinical nurse specialists, and physician assistant (PAs), clinical psychologists, registered dietitians, and nutrition professionals. Medicare Diabetes Prevention Programs should also be enabled to independently offer and bill for this service, rather than limiting coverage to the primary care setting.

  This limitation creates an unnecessary administrative hurdle for patients trying to access effective treatment for a chronic condition and unduly restricts providers who are qualified to deliver this evidence-based therapy. Deregulating these provider type restrictions would streamline care delivery, increase patient access to IBT for obesity, and reduce the administrative burden associated with navigating limited provider pathways.

- Increase Work Relative Value Unites (RVUs) for Psychological and Neuropsychological Testing: In the CY 2024 Medicare PFS final rule, CMS said it welcomed additional feedback on the valuation of the psychological and neuropsychological testing services, and that it may consider updates to the evaluation of these services in future rulemaking. As requested, we provided information on the critical need to increase the 2025 work RVUs for psychological and neuropsychological testing services. Providing a commensurate increase in work RVUs for these services to the increase being provided to work RVUs for psychotherapy services would reduce the administrative and financial barriers to psychologists' provision of testing.

  As CMS stated in the CY2024 proposed rule, "because the physician/practitioner work RVU is developed based on the time and intensity of the service, the issues regarding the valuation of these types of services are particularly pronounced for services that are billed in time units (like psychotherapy codes) that directly reflect the practitioner time inputs used in developing work RVUs, compared to other services that are not billed in time units in which work RVUs are based on estimates of typical time, usually based on survey data" (CMS–1784–P, 52367). Like the

psychotherapy codes, all psychological and neuropsychological testing services are time-based services and meet CMS' rationale for the proposed increase in value.

We request that CMS apply an upward adjustment to the work RVUs of the psychological and neuropsychological testing services that have not yet received both the office and outpatient (O/O) E/M and inherent complexity relativity increase.

- Support psychologists' engagement in meaningful use of electronic health records (EHR): Despite the substantial impact that health behaviors and behavioral disorders have on patient well-being, psychologists have never received support in adopting electronic health records (EHR) capability on par with the support CMS has provided to physicians and other physical health providers. Although some psychologists have been able to adopt EHR technology without assistance, most have been unable to do so.

  CMS should consider providing financial incentives to psychologists, as well as guidance and technical assistance for State Medicaid agencies and Medicare Administrative Carriers, for adoption of EHR systems to improve patient outcomes, support behavioral health integration, and enable their participation in measurement-based and value-based care.