September 12, 2025

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

RE: 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; Medicare Prescription Drug Inflation Rebate Program (CMS-1832-P)

Dear Administrator Oz:

On behalf of the American Association of Psychiatric Pharmacists (AAPP), we appreciate the opportunity to provide feedback on the Centers for Medicare and Medicaid Services' (CMS) 2026 Physician Fee Schedule Proposed Rule. Overall, we applaud CMS for the proposed changes in the rule to create better quality, efficiency, empowerment, and innovation for all Medicare beneficiaries including those with mental health and substance use disorders. Our comments are outlined below.

About AAPP

AAPP is a professional association of nearly 3,000 members who envision a world where all individuals living with mental illness, including those with substance use disorders (SUDs), receive safe, appropriate, and effective treatment. Pharmacist members specialize in psychiatry, substance use disorders (SUD), and psychopharmacology and most are residency trained and Board certified in psychiatric pharmacy holding the BCPP credential (Board Certified Psychiatric Pharmacist). With a significant shortage of mental health care professionals, psychiatric pharmacists offer another resource to improve outcomes for patients with psychiatric disorders and SUDs.

Role of Psychiatric Pharmacists

Pharmacists graduate with a Doctor of Pharmacy degree, requiring six to eight years of higher education to complete, and have more training specific to medication use than any other health care professional. Psychiatric pharmacists, a specialty within clinical pharmacy have specialized training in providing direct patient care and medication management for the complete range of psychiatric disorders and SUDs. Psychiatric pharmacists are not only integral to interprofessional treatment teams but also for decision-making and leadership roles in health care organizations, state and federal organizations, academia, and industry.

Psychiatric pharmacists are important members of the health care team working in collaboration with the patient and other health care providers including, but not limited to, psychiatrists, other physicians, therapists, social workers, and nurses (including advanced practice nurses). Psychiatric pharmacists provide expert, evidence-based Comprehensive Medication Management (CMM) services for the most complex patients with mental health disorders and SUDs. Psychiatric pharmacists increase the capacity

of the health care team to provide care and psychopharmacology expertise, as well as improve patient outcomes and reduce overall health care costs. As medication experts, psychiatric pharmacists are uniquely positioned to facilitate medication access and adherence by identifying and helping to address potential treatment barriers, including prior authorizations and high out-of-pocket patient costs.

Psychiatric pharmacists have a deep understanding of Medications for Opioid Use Disorder (MOUD) that extends beyond that of most other health care providers. When included in the provision of MOUD services through a collaborative practice arrangement, psychiatric pharmacists' involvement has been demonstrated to improve patient adherence and success with buprenorphine treatment for opioid use disorders; reduce per patient dosage of buprenorphine through improved medication management, monitoring and titration; and reduce overall costs. Furthermore, given the insufficient number of providers in addiction medicine, psychiatric pharmacists increase access to SUD treatment by providing medication management, education, monitoring, and follow-up care.

AAPP Comments to 2026 Proposed Physician Fee Schedule

Behavioral Health Service Provisions

1. **AAPP supports behavioral health integration.**

We support CMS's continued efforts to improve access to behavioral health care and integrate behavioral health services into primary care settings. The proposed optional add-on codes for Advanced Primary Care Management (APCM) services represent a meaningful step toward reducing administrative burden and increasing the availability of behavioral health integration (BHI) and Collaborative Care Model (CoCM) services for Medicare beneficiaries.

We also support CMS's continued recognition of the importance of integrated care for individuals with chronic conditions and co-occurring behavioral health needs. As CMS notes, patients are more likely to improve physical health outcomes when their behavioral health concerns are addressed. These proposed changes will facilitate more coordinated, whole-person care, particularly for patients in underserved areas who may otherwise lack access to specialty mental health providers.

Additionally, the proposed elimination of time-based documentation requirements for these new codes will make it easier for primary care practices to deliver team-based behavioral health services, including those involving psychiatric pharmacists. Psychiatric pharmacists are essential members of the health care team, particularly in managing complex medication regimens and monitoring treatment response for patients with co-occurring mental health and substance use disorders. Streamlining billing requirements ensures that services can be delivered more efficiently, especially in practices already providing APCM services.

We encourage CMS to finalize these proposals and to continue identifying opportunities to strengthen and support behavioral health integration across primary care settings. Making it easier for primary care providers to deliver BHI and CoCM services will improve access to mental health care. However, to fully close gaps in care, CMS must also address billing barriers that limit the role of psychiatric pharmacists.

2. **AAPP has concerns about "incident to" billing practices.**

We remain concerned that Medicare's continued reliance on "incident to" billing models for pharmacist services fails to adequately recognize the expertise and role of psychiatric pharmacists. Psychiatric pharmacists are not ancillary staff performing tasks delegated by physicians; but rather act as direct patient care providers on interdisciplinary care teams. Like other specialists such as psychologists, dietitians, or physical therapists, psychiatric pharmacists often manage patients' complex conditions.

The current "incident to" billing structure provides reimbursement for pharmacist services only at the lowest-level evaluation and management (E/M) code, which does not reflect the time, intensity, or complexity of services provided by the psychiatric pharmacist. This underpayment makes it difficult to demonstrate the value of psychiatric pharmacists and therefore harder for clinics to hire psychiatric pharmacists and limits access to care.

As such, we urge CMS to clarify that physicians and healthcare facilities have the authority to bill for all levels of E/M services provided by a psychiatric pharmacist practicing within their scope of practice while under supervision of such a physician. This initiative will support scalability of psychiatric pharmacist services which will increase access to specialized care for our most vulnerable and complex patients.

3. **AAPP urges CMS to consider CMM when addressing the prevention and management of chronic disease.**

We appreciate CMS's focus on advancing prevention and management strategies for chronic disease, including addressing over-reliance on medications, supporting beneficial lifestyle changes, and improving access to team-based care. One proven, scalable intervention that directly supports CMS's goals is comprehensive medication management (CMM) delivered by clinical pharmacists, including psychiatric pharmacists, as part of integrated care teams.

CMM is designed to ensure that every medication a patient is taking is appropriate for their clinical condition, effective for the intended purpose, safe given comorbidities and other medications, and used as intended. When implemented in primary care and specialty settings, pharmacist-provided CMM can:

- Address over-reliance on unnecessary medications;
- Improve medication adherence;
- Enhance medication safety in older adults;
- Target high-risk medication use;
- Reduce hospital readmission;
- Strengthen transitions of care; and
- Monitor and manage metabolic conditions.

Unfortunately, despite this alignment with CMS's stated objectives, current Medicare payment structures do not allow practices to bill directly for pharmacist provided CMM under the physician fee schedule annual payment regulation. Enabling such billing, whether through existing care management codes, new service codes, or inclusion in team-based primary care payment models, would empower practices to fully integrate pharmacists into chronic disease prevention and management workflows.

We urge CMS to consider creating explicit coding and payment pathways for pharmacist-provided CMM through the physician fee schedule. This change would expand access to a high-value service with a

strong evidence base for improving clinical outcomes, lowering costs, and addressing many of the chronic disease priorities identified in the proposed rule.

4. Telehealth and Direct Supervision Provisions.

AAPP supports CMS's proposal to streamline the Medicare Telehealth Services List review process and eliminate the distinction between "provisional" and "permanent" telehealth services. Simplifying the review process and focusing on whether a service can be safely furnished using interactive, two-way audio-video communication is a meaningful step toward ensuring continued access to care for patients who rely on telehealth.

We also support CMS's proposal to permanently allow real-time audio-visual technology to meet the requirements for direct supervision. This change is especially important for team-based care models in mental health settings, where psychiatric pharmacists play a critical role in managing complex medication regimens. Allowing virtual direct supervision will help ensure continuity of care, particularly in rural and underserved communities where in-person or audio-visual supervision may not be feasible. We encourage CMS to explore avenues to make audio-only supervision permanent as well.

Telehealth remains essential for patients with mental health and substance use conditions who face persistent barriers to in-person care. We commend CMS's proposal to remove outdated evidentiary hurdles, such as requiring peer-reviewed literature for low-utilization services, as it appropriately acknowledges the role of clinical judgment in determining whether telehealth is appropriate and safe. We also encourage the agency to continue advancing policies that support permanent telehealth access. These changes will help preserve critical access to behavioral health services for the patients who need them most.

5. AAPP supports CMS recognition of behavioral health professionals and support personnel.

We support CMS's continued recognition of the critical role behavioral health professionals and support personnel play in improving access to care and addressing barriers to treatment. The proposed clarifications regarding the roles of clinical social workers (CSWs), marriage and family therapists (MFTs), and mental health counselors (MHCs) in furnishing certain services are an important step in expanding the behavioral health workforce available to meet the needs of Medicare beneficiaries.

As CMS continues refining these services, we encourage consideration of how psychiatric pharmacists might also contribute meaningfully to such efforts, particularly in medication education, adherence support, and care coordination for patients with complex behavioral health, medical, and/or medication-related needs. We continue to call on CMS and Congress to recognize psychiatric pharmacists as qualified health care professionals (QHPs) so they may bill independently for the care they are uniquely positioned and trained to provide. The Veterans Health Administration, the Bureau of Prisons, the Indian Health Service and tribal health authorities utilize and pay for psychiatric pharmacists as part of the care team to treat patients with mental health and substance use disorders. Medicare is long overdue in expanding the list of mental health and SUD providers to include psychiatric pharmacists, which will expand access to care for our most vulnerable and complex patients. Furthermore, Recognition of psychiatric pharmacists as billing providers will enable growth and sustainability of ambulatory clinic-based psychiatric pharmacist services. .

6. **AAPP supports proposals related to rural health clinics (RHCs) and federally qualified health centers (FQHCs).**

We support CMS's proposal to improve access to behavioral health care in RHCs and FQHCs by aligning payment policies with those in the Physician Fee Schedule (PFS) for BHI and the Psychiatric CoCM. These proposals will streamline documentation requirements, reduce burden, improve transparency, and ultimately encourage the delivery of integrated behavioral health services in RHC and FQHC settings. These changes represent a meaningful step toward advancing integrated care in safety-net settings and reducing administrative barriers for providers treating underserved populations.

As such, we urge CMS to finalize these proposals and continue to prioritize policies that expand access to integrated behavioral health services across all Medicare care settings.

7. **Prescription Drug Monitoring Program (PDMP) Request for Information (RFI).**

We appreciate CMS's ongoing efforts to strengthen the use of Prescription Drug Monitoring Programs (PDMPs) to improve prescribing practices and patient safety. Psychiatric pharmacists play an important role in ensuring the safe use of controlled substances and are often the first to identify potential medication-related risks in patients with mental health or substance use conditions.

AAPP supports continued efforts to improve PDMP interoperability through certified health information technology modules, which will reduce burden and help integrate PDMP use into regular clinical workflows.

We also support expanding the measure to all schedule II drugs as this is already happening in practice. Many states already require checking the PDMP for these additional drugs and AAPP supports making this a uniform, federal policy.

However, we do not support moving the Query of PDMP measure from an attestation-based to a performance-based measure at this time. While we recognize that PDMP access and integration into electronic health records (EHRs) have improved in many settings, a performance-based measure would require significant IT updates and EHR adjustments. This could add operational burden without clearly improving clinical outcomes, particularly given that opioid prescribing has been trending downward and many states already have strong PDMP requirements in place. States also vary in how PDMP checks are conducted and recorded, for example, some states allow pharmacist designees to check PDMPs outside of the EHR, which may create additional complexity in data capture and reporting.[1]

Additionally, we urge CMS to consider the potential for alert fatigue and workflow disruption when adding new operational requirements. Any expansion of the measure should be implemented with attention to provider burden, differences in state law, and the feasibility of accurately capturing PDMP use in diverse care settings.

[1] E.g., in Utah, designees are permitted to do a PDMP check and share the information with the prescriber. However, designees must go to the state PDMP website to do so as they are not able to check through the EHR. In such cases, there will be a need for a mechanism to capture that the PDMP has been checked and that the data is reviewed by the prescriber via the designee.

8. **AAPP urges caution when making changes to 340B.**

We recognize that the Inflation Reduction Act requires CMS to remove 340B units when calculating Part D inflation rebates but recommend that CMS proceed cautiously in implementing this policy beginning January 1, 2026. While we appreciate the intent of the proposed repository and testing, we are concerned that developing a claims-level data system may set new standards for how 340B use is defined and tracked, with effects that extend beyond rebate calculations. As such, we urge CMS to consider the following:

CMS should avoid relying on prescribers National Provider Identifier and contract pharmacy identifiers to flag 340B claims, as this approach is likely to cause confusion and misidentification. We also encourage CMS to ensure that any claims repository does not impose undue certification or reporting burdens on covered entities, and that strict safeguards are in place to protect sensitive data.

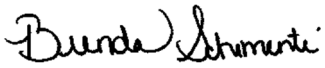
Furthermore, we recommend that CMS pilot test any methodology to ensure accuracy and minimize disruption to covered entities and pharmacy systems. We also ask the agency to avoid shifting costs or administrative burdens to prescribers, pharmacies, or covered entities, and to rely on existing systems and processes to the greatest extent possible.

In thinking of next steps, we strongly encourage CMS to recognize the essential role that 340B plays in supporting safety-net providers and the patients they serve. Hospitals, community health centers, and clinics rely on 340B savings to expand access to medications, sustain rural and behavioral health services, and support uncompensated care. If CMS adopts methodologies that overestimate 340B use or imposes sudden reporting burdens, the resulting loss of resources would harm patients who depend on 340B-funded programs. We therefore support the adoption of a gradual approach to any changes to 340B to ensure compliance with statutory requirements without undermining the program's core mission of expanding access.

Conclusion

Thank you again for the opportunity to comment on the 2026 PFS Proposed Rule. If you have any questions, please do not hesitate to contact me or our Health Policy Consultant, Laura Hanen at lahanen@venable.com. We look forward to working with you.

Sincerely,



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