September 11, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1832-P; Medicare Program; 2026 Payment Policies under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies

Dear Administrator Oz:

The American College of Osteopathic Internists (ACOI), representing the nation's osteopathic internists, medical subspecialists, fellows, residents, and students, welcomes the opportunity to provide comment on the CY 2025 Medicare Physician Fee Schedule (PFS) proposed rule (CMS-1832-P) as published in the Federal Register on July 16, 2025.

The ACOI offers comment on the following topic areas contained within this rule:

- Medicare CY 2026 Conversion Factors
- Efficiency Adjustment
- Indirect Practice Expense Site-of-Service Differential
- Telemedicine
- Integrating Behavioral Health into Advanced Primary Care Management (APCM)
- Prevention and Management of Chronic Disease – Request for Information
- Quality Payment Program

MEDICARE CY 2026 CONVERSION FACTORS

The challenges that confront the Medicare physician payment system threaten beneficiary access to care. This is not alarmist conjecture spread by physician organizations. The Medicare Payment Advisory Commission (MedPAC) has raised concerns about whether beneficiaries will maintain adequate access to care in the future since growth in clinicians' input costs is expected to exceed growth in Medicare PFS payment rates by a greater amount than it did in the two decades prior to the coronavirus pandemic. MedPAC notes this larger gap could create incentives for clinicians

to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare, or vertically consolidate with hospitals.[1]

The current-law payment updates for physician services – 0.75 percent for physicians who are qualifying participants (QPs) in advanced alternative payment models (APMs) and 0.25 percent for physicians who are not QPs – are well below practice cost inflation. Permanent baseline updates to the conversion factors that account for the growth in physician practice costs is needed and is why ACOI has repeatedly called for a physician payment update that is tied to the Medicare Economic Index (MEI), which CMS projects will be 2.7 percent.

While the conversion factors are affected by a positive 0.55 percent budget neutrality adjustment resulting from proposed misvalued code changes and the -2.5 percent efficiency adjustment, the redistributive effect of the proposed payment changes in this rule that negatively impact nearly every specialty and provide extremely modest or neutral benefit to primary care and internal medicine are muted by the temporary, one-year 2.5 percent positive adjustment passed by Congress and enacted earlier this year.

We are disappointed with CMS' sweeping efficiency adjustment and practice expense proposals, as detailed later in this letter, and their broad and lasting implications, including driving experienced doctors out of the workforce sooner than planned. We are equally disappointed that CMS did not propose to correct the utilization estimate for G2211 based on actual claims data from 2024. ACOI refers CMS to the analysis conducted by the American Medical Association RVS Update Committee (AMA RUC) of 2024 Medicare claims data that found G2211 was reported with 11.2 percent of office visits, not the 38 percent of all office visits the Biden Administration estimated. This gross over-estimation resulted in a budget neutrality adjustment that removed $1 billion from the Medicare fee schedule. **We urge CMS to correct the utilization estimate for G2211 by making a prospective budget neutrality adjustment to the 2026 conversion factor.**

EFFICIENCY ADJUSTMENT

CMS proposes to uniformly apply a 2.5 percent cut to the work RVUs for all non-time-based codes/services effective January 1, 2026, by assuming the same amount of physician work efficiency across a large group of services across a fixed period. ACOI's members are diverse in the services they provide to Medicare beneficiaries, with some ACOI members focusing on primary care services, and others on specialty care. Consequently, some ACOI members will be minimally affected by the efficiency adjustment, while others more negatively impacted. Physicians rely on the ability to refer patients to other specialists when necessary for services outside the scope of their experience and training. Reductions in payment for services provided by specialists risk upending referral networks if physician specialists limit the number of Medicare beneficiaries they will accept. The impact could be particularly acute in rural areas where access to physician specialists may already be strained.

[1] June 2025 Report to the Congress: Medicare and the Health Care Delivery System; Medicare Payment Advisory Commission. June 12, 2025. https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system/

ACOI directs CMS to the thorough analysis and comments provided by the AMA RUC on the efficiency adjustment and underscores its opposition to CMS 'proposed sweeping efficiency adjustment on the grounds that it is arbitrary and is not resource based. Further, it is insulting to physicians that CMS would propose an efficiency adjustment based on MEI productivity when it has been decades since Medicare physician payments were linked to the MEI.

CMS proposes an extraordinarily broad application of the proposed efficiency adjustment reduction rather than applying it only to certain services because it states it will "help to improve the overall accuracy of our valuation of these services under the PFS." **Any efforts to improve the accuracy in the valuation of services requires thoughtful review on an individual code/service level**. It is entirely unclear why CMS would assume the same amount of physician work efficiency across thousands of services over a fixed period of time. In fact, CMS seems to contradict itself by stating in the rule that "accruing efficiencies does not apply equally to all services."

CMS suggests the public may submit nominations through the "Potentially Misvalued Codes" process, if it is believed the efficiency adjustment will lead to inaccurate physician time and work RVUs for a particular code. The "Potentially Misvalued Codes" process should not be used as a correction mechanism for an undiscerning efficiency adjustment.

The physician community deserves full transparency from CMS for its data sources used to validate the figures used in Table 11. The MEI productivity adjustment used for the final MEI update reflects the most recent historical estimate of the 10-year moving average growth of private nonfarm business total factor productivity, as calculated by the Bureau of Labor Statistics. Again, physicians do not receive an MEI update; therefore, the efficiency adjustment based on productivity is fundamentally unfair. Furthermore, it is questionable whether a private no-farm productivity adjustment reflects physician services.

Because the 2.5 percent reduction is broadly applied to thousands of services, it may not truly reflect the time and intensity required for treating Medicare beneficiaries with certain conditions. If Medicare beneficiaries have less chronic disease or are less impaired, it may be possible to treat them in less time. However, current evidence points to a Medicare population that has become more complex. With the 68 million people who use Medicare, more than 95 percent have at least one chronic condition and almost half have four or more.[2] Additionally, the large generation of baby boomers is aging into the 65-and-older age group, and people are living longer. As people live longer, the frail population will grow. These patients require more, not less time. The 2.5 percent reduction makes it more difficult for these patients to receive the care that they require.

Lastly, we want to emphasize that CMS' 2.5 percent reduction is not truly about efficiency. True health care efficiency is about outcomes, not just outputs. CMS proposes to recalculate and apply the efficiency adjustment every three years, resulting in a cumulative effect. In fact, by

[2] Valenzano, CS. Tackling Chronic Disease: The Key to Cost-Effective Care; March 6, 2025. https://www.mathematica.org/blogs/tackling-chronic-disease-the-key-to-cost-effective-care#:~:text=Of the 68 million people,average rates of chronic conditions

continuously penalizing physicians for assumed productivity gains, CMS may actually discourage, rather than incentivize, improvements in efficiency and quality.

INDIRECT PRACTICE EXPENSE SITE-OF-SERVICE DIFFERENTIAL

For 2026, CMS proposes a significant change to the practice expense methodology which will recognize greater indirect costs for practitioners in office-based settings compared to facility settings. CMS justifies its proposal on the basis that original practice expense allocation methodologies assumed physicians maintained separate practice locations even if they furnished some care in hospitals. CMS' proposed methodology arbitrarily reduces a key input for the indirect component of the facility practice expense RVU formula, the work RVU input, to 50 percent of the amount used for non-facility practice expense RVU computation.

The premise for this proposed policy is that hospitals receive payments for indirect practice expenses through the outpatient prospective payment system, and the hospital is likely paying overhead costs for employed clinicians, as well as clinicians who are part of hospital-owned practices. Unfortunately, CMS' proposal makes no distinction between employed physicians and those in private practice who still incur overhead and administrative costs for services provided in a facility that are only paid for via the professional claim. Consider the real scenario in which a physician owns his or her practice and is a "preferred provider" for a large hospital system, this proposal would penalize this physician for any services provided at the hospital which could jeopardize the ability to keep their clinic open.

CMS' proposal also fails to recognize that the financial relationships between hospitals and hospital-owned practices vary significantly. In some cases, the hospital may not finance indirect practice expenses for hospital-affiliated clinicians. For example, a hospital may require its hospital-affiliated clinicians to pay to access the hospital system's EHR and updates to that system.

Under the current methodology, the indirect practice expense for each service is calculated using a weighted average of per-hour costs among the specialties that typically perform that service. The per-hour cost data that are currently used to calculate RVUs are from survey data are almost 20 years old. The AMA contracted with Mathematica to conduct a technical and comprehensive survey – the Physician Practice Information (PPI) Survey – of physician practice costs. This survey was completed in September 2024 with 380 practices providing usable data for 831 departments, which encompassed 18,086 physicians, resulting in a 6.8 percent response rate. This data was shared with CMS in January 2025. **CMS should delay implementation of any modifications to the indirect practice expense methodology until the 2024 PPI data are implemented.**

TELEMEDICINE

Section 2207 of the Full-Year Continuing Appropriations and Extensions Act of 2025 [P.L. 119-4] extended the availability of telehealth services that can be furnished using audio-only technology and provided for the extension of other public health emergency (PHE)-related

flexibilities, including removal of the geographic and location limitations under section 1834(m) of the Act through September 30, 2025.

Utilization of telehealth has fallen since its peak during the COVID-19 pandemic but remains elevated, easing access to care for Medicare beneficiaries. Congress needs to extend the PHE-related telehealth flexibilities because telehealth benefits not just those who live in rural areas and those who require behavioral health services; it also benefits those who lack easy access to transportation, have limited mobility, or other barriers that make it challenging to access health care in the office setting. Extending the PHE-related telehealth flexibilities also provides an opportunity to gather knowledge and continue to learn best practices.

Medicare Telehealth Services List and Review Process

ACOI supports CMS' proposal to simplify the telehealth list review process by removing steps four *(consider whether the service elements of the requested service map to the service elements of a service on the list that has a permanent status described in previous final rulemaking)* and five *(consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service when the patient, who is located at a telehealth originating site, receives a service furnished by a physician or practitioner located at a distant site using an interactive telecommunications system)* of the current five-step process for additions, deletions, and changes to the Medicare telehealth services list.

By focusing review, as proposed, on whether the service can be furnished using an interactive telecommunications system for purposes of adding, deleting or changing services on the telehealth list, we agree with CMS that physicians and other practitioners can exercise their professional judgment, including review and use of clinical practice guidelines and peer-reviewed literature, in determining whether a service can be safely furnished via telehealth based on a patient's clinical needs.

Frequency Limitations

ACOI welcomes CMS' proposal to permanently lift the frequency limits on providing subsequent hospital inpatient and nursing facility visits and critical care consultations furnished via telehealth. The environment for telehealth services has transformed in the many years since CMS first imposed frequency limits for these services. We therefore encourage CMS to finalize its proposal.

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

ACOI previously supported CMS' proposal to permit virtual direct supervision as permanent policy for a subset of services requiring direct supervision, which CMS views as being typically performed in their entirety by auxiliary personnel, including services described by CPT code 99211 which, by definition, "may not require the presence of a physician or other qualified health professional." For other services, CMS previously finalized that virtual direct supervision would continue to be allowed through December 31, 2025. ACOI believes a policy of direct supervision through communications technology should be made permanent in an effort to address health

care professional and physician workforce shortages, which are severe in certain parts of the United States. A permanent policy of virtual direct supervision will also facilitate innovative care delivery models, including "hospital at home." As such, **ACOI supports CMS' proposal to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for all services described under § 410.26 (incident-to services), except for services that have a global surgery indicator of 010 or 090.** Similar to CMS' rationale for simplifying the telehealth list review process, we support giving physicians and other practitioners flexibility to use their professional judgment to determine the appropriate supervision modality on a case-by-case basis.

Teaching Physicians' Billing for Services Involving Residents with Virtual Presence

ACOI asks CMS to reconsider its proposal to transition back to its pre-public health emergency policy, which, while maintaining the rural exception, would no longer allow teaching physicians to have a virtual presence (e.g., a 3-way telehealth visit, with the patient, resident, and teaching physician in separate locations) for purposes of billing for services furnished involving residents in all teaching settings beyond December 31, 2025.

Based on ACOI member experiences, there are times when telemedicine is used for patients at home when the resident is covering an outreach clinic area, and the attending physician must be in the inpatient setting. These scenarios take place in metropolitan statistical areas (MSAs) and non-MSA areas. **ACOI supports a permanent policy allowing virtual supervision of residents for both non-MSA *and* MSA areas. We also believe this policy should include virtual supervision of residents who are providing in-person services.**

The Accreditation Council for Graduate Medical Education (ACGME) guidelines state direct supervision of residents can occur when "the supervising physician and/or patient is not physically present with the resident, and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology." Alongside ACGME guidance, teaching physicians should have the discretion to determine when their virtual presence would be clinically appropriate, based on their assessment of the patient's needs and the competency level of the resident. **We ask that CMS apply the same rationale it is using for the other proposed telemedicine proposals – deference to a physician's expert judgement on a case-by-case basis – for maintaining virtual teaching physician supervision within MSAs**.

INTEGRATING BEHAVIORAL HEALTH INTO ADVANCED PRIMARY CARE MANAGEMENT (APCM)

CMS proposes to create optional add-on codes for APCM (HCPCS codes G0556, G0557, G0558) that would facilitate providing complementary behavioral health integration (BHI) services by removing the time-based requirements of the existing BHI and Collaborative Care Model (CoCM) codes. CMS believes that removing the time-based requirements will alleviate burden by reducing the documentation requirements for billing, which CMS expects will make primary care physicians more likely to furnish BHI and CoCM services.

First, we want to note that BHI services are critical in other specialties beyond primary care. Second, while we appreciate CMS' intention to alleviate burden by reducing the documentation requirements for billing BHI services, creating new G codes for services already described in CPT may unnecessarily add confusion for physicians across payers. Instead, **ACOI recommends that CMS work directly with the AMA CPT Editorial Panel on comprehensive coding changes that reduce administrative burden.**

PREVENTION AND MANAGEMENT OF CHRONIC DISEASE – REQUEST FOR INFORMATION

How could CMS better support prevention and management, including self-management, of chronic disease?

The most effective way to support prevention is to recognize it as a shared responsibility between clinical medicine and public health. The single most impactful action the federal government can take is to uphold a robust, sustained investment in the nation's public health infrastructure, including the Centers for Disease Control and Prevention (CDC), as well as state and local health departments. Regrettably, President Trump's Fiscal Year 2026 Budget and recent executive actions erode these investments. Physicians cannot succeed in their efforts to prevent chronic disease without a fully funded public health system as an essential partner for community resources, data, and education.

The federal government must also commit to specifically addressing the disproportionate burden that people of color carry—largely driven by decreased access to preventive services due to lack of insurance. Strategies should include expanding, not creating barriers to, affordable health care coverage, investing in culturally responsive health education, and increasing community-based programs in underserved neighborhoods.

Over the past several decades, the AMA CPT Editorial Panel has demonstrated its leadership by creating foundational coding frameworks, starting with glucose monitoring services and expanding to remote patient monitoring (RPM), remote therapeutic monitoring (RTM), and self-measured blood pressure monitoring (SMBP). Payment for these types of services enhances clinical judgment, streamlines workflows, and improves patient outcomes—particularly for those managing complex, multi-morbid conditions. These tools allow physicians to detect early warning signs, adjust treatment plans proactively, and reduce unnecessary hospitalizations. This is especially vital in rural communities, where geographic isolation and limited financial resources often hinder access to consistent care. Remote monitoring bridges that gap by enabling continuous oversight without requiring frequent in-person visits. For patients with mobility challenges, transportation barriers, or limited broadband access, even modest improvements in remote care infrastructure can be life-changing.

As CMS explores opportunities for supporting prevention and management, we remind CMS that patients with chronic disease require care coordination. Isolating services outside physician-led teams risks exacerbating long-standing challenges, particularly in rural areas where access is already limited. CPT supports physician leadership by embedding new services, such as digital monitoring, therapeutics, or behavioral interventions, into the broader framework of coordinated care.

Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, please provide specific examples.

For prevention and chronic care services not adequately captured by the current physician fee schedule code set, simply adding more fee-for-service codes is a flawed solution. This approach often increases administrative burden, fragments care, and fails to capture the continuous, non-linear nature of chronic disease management. Instead, the focus should be on developing comprehensive payment models that provide practices with the resources and flexibility to deliver whole-person care over time, rather than creating more billing complexity.

Medicare can also better support physicians and care teams by providing opportunities for engaging with community-based lifestyle change programs. To facilitate this engagement CMS should collaborate with the CDC which has a history of pilot testing, evaluating, and creating standards for evidence-based programs that are already being implemented or can be adopted by organizations in a variety of settings and delivery modalities.

CMS can incentivize physicians to provide brief intervention and referral for lifestyle change by paying physicians for the service in addition to the payment for the visit, as smoking and tobacco use cessation counseling (CPT codes 99406 and 99407) are currently paid.

Are there current services being performed to address social isolation and loneliness of persons with Medicare, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, what evidence has supported these services, and what do these services entail? What services have been delivered by Medicare providers or community-based organizations, including area agencies on aging and other local aging and disability organizations? What has been the impact?

There are several services aimed at addressing social isolation and loneliness among Medicare beneficiaries where the time, complexity, and resources involved are not fully captured under current physician fee schedule codes. These services often include screening for loneliness and social isolation, connecting patients to community resources, facilitating group-based or virtual activities, care coordination, counseling, and frequent follow-up, which require significant provider or care manager effort not reflected in reimbursement.

Evidence supports these interventions.[3,4,5,6] Objective isolation is linked to higher Medicare spending, greater institutionalization, and higher mortality, while social engagement programs have demonstrated improvements in health, reductions in loneliness, and lower hospitalization rates. Area Agencies on Aging and local organizations deliver programs such as senior wellness activities, congregate meals, volunteer engagement, virtual programming, and technology training to foster connection and resilience in older adults. However, the impact is limited by insufficient reimbursement for the time providers and care teams invest in screening, coordination, and facilitating these non-clinical but high-impact services, leaving significant unmet need and opportunity for expanded support.

These services and related programs need adequate funding from the federal government to meet the growing demand of the expanding Medicare population. ACOI therefore urges the Trump Administration to work with Congress to increase funding for these services outside of the Medicare PFS, which is a budget neutral system. Adding these services could result in cuts to other medical services, including preventive screenings, chronic disease management, and treatment services, which would harm Medicare patient access to care.

Are there current services being performed that improve physical activity, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? How should CMS consider provider assessment of physical activity, exercise prescription, supervised exercise programs, and referral, given the accelerating use of wearable devices and advances in remote monitoring technology?

The rapid advancement of wearable device technology and remote monitoring capabilities requires optimizing interoperability and the ability for patients to share their physical activity data seamlessly with their clinicians. ACOI encourages CMS to continue working with the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT on optimizing interoperability. We also encourage the testing and evaluation of effective clinical practices linking medical and digital interventions.

Should CMS consider creating separate coding and payment for intensive lifestyle interventions, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set, and how should these interventions be prioritized? If so, what evidence has supported these services, and what do the services entail? How would additional coding and payment be substantively different from coding and payment for Intensive Behavioral Therapy?

[3] Shaw JG, Farid M, Noel-Miller C, Joseph N, Houser A, Asch SM, Bhattacharya J. Social Isolation and Medicare Spending: Among Older Adults, Objective Isolation Increases Expenditures While Loneliness Reduces Them. Journal of Aging and Health. 2017;29(7):1119-1143. doi:10.1177/0898264317711602

[4] Choi SK, Wilson C, Fennie KP, et al. Social Isolation Changes and Long-Term Outcomes Among Older Adults in the US. JAMA Network Open. 2024;7(6):e2821456. doi:10.1001/jamanetworkopen.2024.21456

[5] Karpman M, Zuvekas SH, Eicheldinger C, et al. Patient-Provider Communication for Lonely, Socially Isolated Adults in Medicare. Patient Education and Counseling. 2025. doi:10.1016/j.pec.2025.04.010

[6] AARP Public Policy Institute. Connecting with Medicare Beneficiaries to Lessen Social Isolation. Elevance Health; 2024.

Intensive lifestyle interventions (ILIs) typically involve comprehensive assessment, personalized counseling, behavioral change techniques, and frequent follow-up-services demonstrated in clinical trials, especially in programs like the Diabetes Prevention Program, to reduce the incidence of chronic diseases such as diabetes and cardiovascular disease.

ILIs differ from Intensive Behavioral Therapy (IBT) in that IBT codes primarily focus on counseling for obesity or tobacco cessation, whereas ILIs encompass a broader range of preventive lifestyle modifications including nutrition, physical activity, sleep, stress management, and medication adherence. ILIs are more comprehensive and intensive, requiring multidisciplinary approaches and often extending over months.

Evidence supporting ILIs includes randomized controlled trials showing sustained weight loss, improved glycemic control, and decreased cardiovascular events, alongside cost-effectiveness data demonstrating health care savings from delayed onset or progression of chronic diseases.[7,8]

There is a need to adequately recognize the resources involved with intensive lifestyle interventions; however, time-based CPT codes are an inadequate and simplistic solution. Payment must be structured to account for the extensive initial training, the need for ongoing supervision to maintain fidelity, the non-linear path of patient behavior change, and the integration of these services into a longitudinal care plan. A 15-minute code cannot capture this complexity.

Should CMS consider creating separate coding and payment for medically-tailored meals, as an incident-to service performed under general supervision of a billing practitioner?

Medically-tailored meals involve providing home-delivered meals specifically designed by registered dietitians to meet the unique nutritional needs of patients with complex, diet-sensitive chronic conditions after hospital discharge or repeated emergency care visits. These meals, when paired with nutrition counseling and monitoring, support recovery, prevent readmissions, and improve health outcomes. To be effective, medically-tailored meal services must be part of a coordinated care plan.

Similar to services to address social isolation, medically-tailored meal programs need adequate funding (outside the Medicare PFS) from the federal government to meet the growing demand of the expanding Medicare population.

Are there technical solutions that would enhance the uptake of the annual wellness visit (AWV), or the improving accessibility, impact, and usefulness of the AWV? How can CMS better support practitioners and beneficiaries related to the AWV? Should CMS consider moving some of the required components of the AWV to optional add-on codes of the AWV instead, with the intent of decreasing burden, improving uptake, and allowing practitioners to select additional AWV elements that may be more relevant to particular patients?

[7] CDC Diabetes Prevention Program Research Group, 12-year follow-up, N Engl J Med, 2019.
[8] Wharton S et al., Efficacy of intensive lifestyle intervention for obesity, Lancet Diabetes Endocrinol, 2020.

Technical solutions exist that can enhance uptake, accessibility, impact, and usefulness of the Annual Wellness Visit (AWV). These include electronic health record integrated reminder systems, patient portals with pre-visit questionnaires, telehealth options, and automated workflows that delegate parts of the visit to care managers or health coaches. Tools that collect and analyze social determinants of health (SDOH), cognitive screening, and lifestyle data streamline provider assessments and risk stratification.

CMS can better support practitioners and beneficiaries by promoting interoperability standards, incentivizing team-based care models, providing education on AWV components, and supporting telehealth delivery of wellness services. Additionally, facilitating data sharing and documentation tools that reduce administrative burden would improve efficiency.

CMS could consider moving some required AWV components—like social risk assessments or advance care planning—to optional add-on codes. Doing so has the potential to reduce the burden of the initial visit, increase overall AWV uptake, and allow providers to tailor visits by selecting additional elements most relevant to individual patient needs, improving patient-centered care. However, the approach of optional add-on codes would most likely increase administrative burden.

Motivational Interviewing

ACOI offers the following in response to CMS questions pertaining to motivational interviewing (MI):

What is the best definition and description of motivational interviewing?

The definition provided by CMS from Miller & Rollnick is appropriate: "a collaborative, goal-oriented style of communication with particular attention to the language of change... designed to strengthen personal motivation for and commitment to a specific health goal." It is critical to emphasize that this is a complex clinical skill focused on evoking a patient's own reasons for change, not a simple advice-giving technique.

What types of clinical staff should be able to perform motivational interviewing under the general supervision of a billing practitioner?

Before any clinical staff (including health coaches) are permitted to perform and bill for MI under general supervision, it is imperative that CMS works with professional medical and credentialing bodies to establish rigorous, enforceable national standards for training, certification, and scope of practice. Patient safety and quality of care must be the primary consideration.

How long does a session of motivational interviewing typically last? If we were to create coding and payment for motivational interviewing, what should the time-based requirements of the code be?

Behavior change is a process, not a procedure. It does not fit neatly into discrete time blocks. While some studies note effects from brief encounters, effective MI often requires multiple sessions of varying lengths over time. We strongly caution against creating a rigid, time-based code, as it would create an artificial construct that does not reflect the reality of patient care and would incentivize "checking a box" rather than effective counseling.

We heard from interested parties that in many clinics, health coaches perform services under general supervision, and that there may be substantive overlap with motivational interviewing. To what extent are the services performed by health coaches encompassed by motivational interviewing?

It is not common to have “health coaches” in, or employed by, primary care or specialty clinics. These may be utilized by patients on their own, but it is not typical for them to be part of the health care team. Before CMS considers creating payment for services delivered by health coaches on an "incident-to" basis, the agency must work with professional medical societies and credentialing bodies to establish rigorous, national standards for training, certification, and scope of practice. This is essential to ensure patient safety, guarantee a minimum standard of quality, and protect supervising physicians from undue liability.

What training is required to effectively perform motivational interviewing? Are there agreed upon national training or certification standards for health coaches? If so, what are they? Do states have separate training or certification standards for health coaches?

Currently, ACOI is unaware of universally agreed-upon national training or certification standards for health coaches. This lack of a unified professional standard is a significant barrier to safe and effective integration into the Medicare program.

To what extent would health coaches be able to perform motivational interviewing incident-to billing practitioners under general supervision?

There is significant potential overlap, as MI is a core competency for effective health coaching. However, without national certification standards, there is no way to guarantee that an individual calling themselves a "health coach" is proficient in MI. The concepts are linked, but the skills are not interchangeable without standardized, required training.

Can motivational interviewing and health coaching appropriately be performed via audiovisual or audio-only synchronous telecommunication?

Yes. Modality should not limit the ability to provide MI.

QUALITY PAYMENT PROGRAM

Physicians value meaningful quality improvement activities; however, the lack of an inflationary update and payment reductions that would result from CMS' proposed practice expense proposal and efficiency reductions make it increasingly difficult for practices, especially solo and small practices, to dedicate resources to successful participation in the Merit-based Incentive Payment System (MIPS).

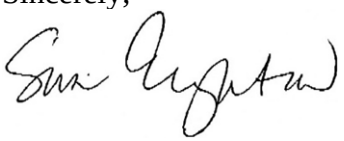
On this basis, the ACOI recommends the following to CMS:

- Maintain the MIPS performance threshold at 75 points in 2026.
- Continue to encourage *voluntary* participation in MIPS Value Pathways (MVPs), including subgroup participation, and do not sunset traditional MIPS.
- Allow multispecialty groups that are small practices (i.e., 15 or fewer clinicians) to report MVPs as a group practice rather than subdividing into subgroups or reporting as individuals.
- Apply the small practice exception at the specialty level within larger multispecialty practices and implement additional regulatory burden reducing changes to incentivize MVP participation among multispecialty groups.

CONCLUSION

ACOI appreciates the opportunity to comment on the CY 2026 PFS proposed rule and issues of importance to osteopathic internists. Any questions or requests for additional information should be directed to Tim McNichol, ACOI Deputy Executive Director, at tmcnichol@acoi.org or (301) 231-8877.

Sincerely,



Susan M. Enright, DO, MACOI
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