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The Honorable Dr. Mehmet Oz, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
File Code CMS-1832-P  
Baltimore, MD 21244–8010

**CMS-1832-P; 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; and Medicare Prescription Drug Inflation Rebate Program**

Dear Administrator Oz:

The American Psychiatric Association (APA), the national medical specialty society representing over 39,200 psychiatric physicians and their patients, appreciates the opportunity to comment on the proposed changes to the CY 2026 payment policies under the Physician Fee Schedule, Part-B payment and coverage, and quality payment programs.

According to the National Institute of Mental Health (NIMH), more than **1 in 5 adults** in the United States experience some form of mental illness in any given year.<sup>i</sup> This translates to **over 50 million Americans** living with mental health conditions such as depression, anxiety, substance use disorders, and more. Untreated mental illness, including substance use has a resounding impact in our communities resulting in poor educational attainment, unstable housing, higher unemployment, poverty, and trauma. Early intervention, prevention, and treatment lead to cost savings for individuals, health insurers, government, and society.<sup>ii</sup> This includes ensuring the presence of a full range of services—a care continuum—to meet people’s needs in the most accessible, least restrictive environment. This continuum must offer a spectrum of services including screening and early identification in primary care settings, accessible outpatient care, crisis intervention, rehabilitation and recovery support, and inpatient psychiatric treatment.

Data show that 60–70% of individuals with mental health disorders are treated exclusively in primary care environments.<sup>iii</sup> The integration of behavioral health services into primary care settings is not just a logical step forward, it is an urgent necessity for ensuring that individuals receive the whole-person care they need. Behavioral health integration in primary care has been shown to reduce barriers to

care, improve treatment outcomes, and lower healthcare costs.<sup>1</sup> Despite the clear benefits, reimbursement for behavioral health services integrated into primary care remains a significant challenge. CMS has made some strides by providing coverage for the Collaborative Care Model (CoCM), which reimburses primary care providers for team-based care within their practices. However, reimbursement rates are inadequate to sustain these services over time, particularly for smaller independent practices, hindering the widespread adoption of this model.

To ensure this evidence-based model of care remains available, **we urge CMS to increase payment rates for the proposed Collaborative Care Services codes designated for use with the Advanced Primary Care Management services.** We also ask CMS to **work with other stakeholders to address barriers to care posed by co-insurance/co-pays such as designating CoCM services as preventive services by the Secretary in order to eliminate cost-sharing requirements for these services, which are cited as a significant reason why patients choose not to engage in or continue to receive care through the model.**<sup>2</sup> The CoCM has tremendous potential to produce significant cost savings in line with preventive services, as one cost/benefit analysis demonstrated that this model has a 12:1 benefit to cost ratio for the treatment of depression in adults.<sup>3</sup>

On the other side of the care continuum, inpatient psychiatric services serve as a crucial foundation of local mental health systems, providing essential services for individuals experiencing acute mental illness, much like inpatient medical care supports those with acute medical needs. They offer a vital level of care for individuals experiencing a mental health crisis. Unfortunately, the number of psychiatric beds across private and public sectors has dropped significantly in the past 60 years.<sup>4</sup> Today, amidst a mental health crisis, psychiatric inpatient beds are too often not available when needed. As a result, people with mental illnesses end up staying in emergency departments, also known as boarding, or being discharged prematurely. In worst-case scenarios, inaccessible treatment results in homelessness or involvement with the criminal justice system. **We ask that the Administration ensure that psychiatric facilities have sufficient funding to support the availability of inpatient beds in a timely manner for any individual for whom inpatient care is needed.**

**Determination of PE RVUs (Practice Expense Relative Value Units)** (section II.B.) (pg. 32354)  
*Facility and Nonfacility Costs: Site of Service Differential* (pg. 32355)

**APA supports CMS' goal of better recognizing the true cost of physician work in the non-facility setting. However, we oppose CMS' proposal to arbitrarily reduce indirect practice expense RVUs for all facility-based services.** These steep RVU and payment reductions would affect psychiatrists, particularly geriatric

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<sup>1</sup> Horstman CE, Federman S, Williams II R. Improving Health Care Quality: Integrating Primary Care and Behavioral Health to Address the Behavioral Health Crisis. *Commonwealth Fund* explainer. September 15, 2022.

[https://www.commonwealthfund.org/publications/explainer/2022/sep/integrating-primary-care-behavioral-health-address-crisis?utm\\_source=chatgpt.com](https://www.commonwealthfund.org/publications/explainer/2022/sep/integrating-primary-care-behavioral-health-address-crisis?utm_source=chatgpt.com)

<sup>2</sup> Blackmore MA, Patel UB, Stein D, et al. Collaborative Care for Low-Income Patients From Racial-Ethnic Minority Groups in Primary Care: Engagement and Clinical Outcomes. *Psychiatr Serv.* 2022;73(8):842-848.

<https://pubmed.ncbi.nlm.nih.gov/35139653/>

<sup>3</sup> Washington State Institute for Public Policy Benefit-Cost Results for Adult Mental Health.

<https://www.wsipp.wa.gov/BenefitCost?topicId=8>

<sup>4</sup> APA Report on "The Psychiatric Bed Crisis in the US: Understanding the Problem and Moving Toward Solutions", May 2023.

<https://www.psychiatry.org/psychiatrists/research/psychiatric-bed-crisis-report>

psychiatrists, who furnish facility-based services to a growing patient caseload due to the aging population. Lower reimbursement levels could lead to staffing shortages and recruitment challenges as psychiatrists leave the facility setting, diminishing access to this level of care for Medicare's most vulnerable patients.

This proposed policy risks serious unintended consequences, particularly for patient care in inpatient psychiatric units and skilled nursing facilities. An existing shortage of inpatient psychiatric beds would be worsened and could lead to a closure of units, particularly in rural communities or general hospitals. Downstream impacts would be an increase in visits to the emergency department (ED) and more frequent and prolonged boarding of patients in psychiatric distress in the ED. The Agency for Healthcare Research and Quality (AHRQ) found that this longstanding migration of healthcare services from facility to outpatient care is a key driver in the reduction of available inpatient psychiatric beds and rise of ED boarding.<sup>5</sup>

Per Table 92 in the proposed rule, psychiatry is expected to see a 9% reduction in PE RVUs for services billed in a facility setting, leading to a combined impact of -9% on total allowed charges. For example, CPT® code 99232, one of the most common services furnished by psychiatrists in facilities, would see its practice expense RVUs cut by 58 percent, from 0.95 in 2025 to 0.40 in 2026. Similar reductions are proposed for other hospital and nursing facility E/M services. While practice expenses for facility services are lower than those in physician-owned practices, they are not zero. Additionally, many office-based psychiatrists still provide facility care, and these proposed cuts would place unsustainable strain on independent psychiatrists.

To avoid these unintended consequences, **APA requests CMS to exempt these services along with all behavioral health codes from the proposed site-of-service cuts. Specifically, we recommend CMS continue to use full physician work values to allocate indirect PE for hospital or observation codes (CPT® 99221–99239) and nursing facility codes (CPT® 99304–99316).** This approach would better reflect the actual costs faced by psychiatrists providing care in facilities and help maintain patient access.

When modernizing practice expense valuation, we ask CMS to proceed cautiously ensuring that any updates to data sources or methodology accurately reflect psychiatry practice costs and do not inadvertently undermine access to behavioral healthcare in critical facility-based settings.

**Development of Strategies for Updates to Practice Expense Data Collection Methodology** (pg. 32367)  
*Use of OPFS data for PFS Rate setting* (pg. 32374)

APA acknowledges the concerns raised by CMS about the American Medical Association (AMA) Physician Practice Information (PPI) Survey data including low response rates and questions about the validity of the data. CMS has proposed the use of external data sources, such as the Hospital Outpatient Prospective Payment System (HOPPS), in place of or in combination with the PPI Survey data as an alternative for updating the practice expense inputs.

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<sup>5</sup> Robin M. Weinick, Sean Bruna, Rachael M. Boicourt, Sean S. Michael, and Laura L. Sessums, *AHRQ Summit to Address Emergency Department Boarding: Technical Report* (Rockville, MD: Agency for Healthcare Research and Quality, January 2025), AHRQ Pub. No. 25-0042, <https://www.ahrq.gov/sites/default/files/wysiwyg/topics/ed-boarding-summit-report.pdf>.

Rather than using external data, **we suggest CMS consider ways to simplify the practice expense data collection process and the methodology** to improve participation and understanding of the survey process. If, however, CMS moves forward with the proposal on the use of external data sources, **we strongly recommend that all stakeholders be given the opportunity to evaluate whether proposed external data sources are reliable, valid, and truly representative of medical practice.** In the case of the HOPPS data, we have concerns that generalizing this facility-based data may not accurately reflect costs across all psychiatric services. **Any proposed changes to the process must be transparent and ensure that all stakeholders have sufficient time to thoroughly review specialty-specific impacts and provide feedback.**

**Payment for Medicare Telehealth Services Under Section 1834(m) of the Act** *(section II.D.) (pg. 32386)*

**APA supports CMS' proposal to revise and simplify the 5-step process used to review requests to add services to the Medicare Telehealth Services List.** We agree that the focus of the review should be based on whether a service can be furnished using an interactive telecommunications system. We appreciate CMS' emphasis on the important role of the professional judgment exercised by physicians and others, particularly in determining whether an individual patient should receive a service via telehealth.

*Changes to the Medicare Telehealth Services List (pg. 32386)*

- **Multiple-Family Group Psychotherapy** *(pg. 32390)*  
**APA thanks CMS for its continued efforts to expand access to behavioral health services via telehealth and strongly supports the proposal to add CPT® code 90849 (Multiple-Family Group Psychotherapy) to the Medicare Telehealth Services List.** Multiple-family group psychotherapy is an important service that enhances treatment engagement, improves family support, and promotes recovery for both adult and adolescent patients. APA agrees that this service now meets CMS' criteria for inclusion, given its active payment status under the PFS and the feasibility of delivering all elements via interactive telecommunications technology. Allowing Medicare beneficiaries to access multiple-family group psychotherapy through telehealth will expand availability of this evidence-based intervention, reduce barriers to care, and strengthen family involvement in treatment.
- **Telemedicine E/M Services** *(pg. 32392)*  
**APA supports CMS' proposal to not place the CPT® codes 98000–98015 on the telehealth list as telehealth is inherent in the description. We also support CMS' 2024 decision to not provide coverage of the 16 Telemedicine Evaluation and Management (E/M) Services (CPT® Codes 98000–98015) but instead maintain longstanding policy to use the existing outpatient evaluation and management services (CPT® codes 99202–99215) to describe services provided by telehealth, including audio-only care.** This approach is in line with billing requirements for all other services provided via telehealth and ensures equal payment for equivalent work.

*Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations (pg. 32392)*

APA thanks CMS for its review of telehealth utilization data and supports the proposal to permanently remove frequency limitations on subsequent inpatient visits (CPT® codes 99231, 99232, 99233) and subsequent nursing facility visits (CPT® codes 99307, 99308, 99309, 99310) furnished via telehealth. The experience during the COVID-19 Public Health Emergency (PHE) demonstrated that lifting these arbitrary limits improved access to clinically appropriate care without evidence of overutilization or risk to patient safety.<sup>6</sup> We agree with CMS' conclusion that physicians and other practitioners are best positioned to exercise their professional judgment in determining the appropriate modality of care, and we appreciate CMS' commitment to advancing policies that support patient choice, improve care continuity, and remove unnecessary barriers to telehealth.

**Other Non-Face-to-Face Services Involving Communications Technology under the PFS (pg. 32393)**

*Direct Supervision via Use of Two-way Audio/Video Communications Technology (pg. 32393)*

**APA supports making permanent the ability to provide direct supervision through secure two-way audio/video communications.** This approach maintains the quality of supervision for incident-to services while increasing flexibility and access, especially in rural or underserved areas.

*Proposed Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence (pg. 32395)*

**APA does not support CMS' proposal to revert to pre-pandemic rules regarding virtual supervision of residents which would limit its use to designated rural areas.** Telehealth care by residents has been demonstrated throughout the Public Health Emergency to be a safe and effective strategy for maintaining, and in many cases increasing, access to care. Teaching physicians are ultimately responsible for the clinical outcomes of the care provided by residents. Guardrails through the Accreditation Council for Graduate Medical Education (ACGME) and other accrediting organizations ensure patient safety and oversight of residents under virtual supervision. Additionally, the removal of virtual supervision hinders residents' ability to meet the ACGME minimum supervision requirements. Continuing virtual supervision for patients and residents in metropolitan statistical areas ensures patients maintain access to effective care.

**We ask CMS to reconsider and allow the virtual supervision of psychiatry residents on a permanent basis or allow programs to have at least 50 percent of visits with a resident be supervised virtually, while requiring the remaining in-person visits with the faculty.** This latter option would allow programs to potentially recruit more qualified faculty to positions while allowing them to maintain roles outside of training program locations, also reducing the burden on residents to travel extended times to receive the mandatory supervised training.

Further, residents delivering telehealth with supervision from a teaching physician ensures they are trained for telehealth service delivery when they enter the physician workforce. Reducing this flexibility

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<sup>6</sup> Jennings Hernandez, *Impacts of Telehealth on Access-to-Care for Mental Health Patients*, *International Neuropsychiatric Disease Journal* 18, no. 2 (September 19, 2022): 1–7, <https://doi.org/10.9734/INDJ/2022/v18i2345>.

would reduce the ability of the healthcare system to meet patient care and trainee supervision demands, risking closure of medical education programs due to the lack of teaching physicians and reduced Medicare reimbursement, further compounding the current workforce shortage and challenging the education pipeline for future clinicians.

APA provides the following examples of programs that will be challenged to continue to provide training opportunities in their communities. While anecdotal, these stories are a part of a greater trend that is occurring across the country.

- The Medical College of Wisconsin-Wausau Program has been unable to recruit a qualified child and adolescent psychiatry faculty to supervise the required rotations. The program currently uses faculty from Illinois, Tennessee, and Georgia to supervise the patient visits. If virtual supervision is not maintained at some level, the burden will be placed on residents to travel to larger cities for these rotations.
- The Medical College of Wisconsin- Green Bay Program has been unable to recruit a qualified consult-liaison faculty to supervise residents and currently uses a faculty from the Milwaukee area, a two-plus hour car trip away. Again, if these policies revert, the residents would be required to complete these rotations in Milwaukee or another larger urban area.

Without making permanent the ability for psychiatry residents to be supervised virtually, many programs such as the Medical College of Wisconsin, will not be able to fill their Graduate Medical Education slots that have been increased over the past year to fill the necessary vacancies of psychiatrists across the country. These programs will cease to exist in communities where care is needed most.

In addition, this proposal appears inconsistent with CMS' position on other matters relating to supervision via telehealth. CMS has proposed to permit the supervising practitioner to be virtually present for services that do not carry 010- or 090-day global periods. Importantly, this flexibility is not confined to services furnished through telehealth; rather, supervising practitioners may be deemed "immediately available" through audio-visual technology even when services are delivered in person by clinical staff, provided the supervision is determined appropriate based on the physician's clinical judgment. We respectfully submit that there is no policy rationale for precluding supervising physicians from exercising this same clinical discretion with respect to services furnished virtually by residents.

Additionally, we request clarification from CMS on how the proposed return to the pre-PHE policy applies in scenarios where the patient is participating virtually, while both the resident and the teaching physician are physically co-located. Specifically, would this arrangement satisfy the requirement for the teaching physician's physical presence during the key portions of the service? Clear guidance on this point will help ensure consistent application of supervision rules across telehealth encounters.

#### **Distant Site Requirements**

During the COVID-19 PHE, CMS allowed practitioners to render telehealth services from their home while continuing to bill from the location where they had been enrolled. CMS then extended this flexibility until the end of CY 2025 stating that given the shift in practice patterns toward models of care that include the

practitioner's home as the distant site, it would be appropriate to continue this flexibility as CMS considers various proposals that may better protect the safety and privacy of practitioners.

However, CMS did not address the extension of this flexibility in the current rulemaking. If this policy lapses, practitioners will no longer be able to use their practice location instead of their home address in enrollment when providing telehealth services. Mental health providers face unique safety and privacy risks if compelled to disclose their personal residence information. Maintaining the ability to use a professional practice address protects provider safety, preserves appropriate professional boundaries, and ensures continued access to telehealth services for patients. **APA strongly recommends that CMS permit practitioners to use their enrolled practice location instead of their home address when providing telehealth services from their home permanently.**

**Valuation of Specific Codes** (*section II.E.*) (pg. 32397)  
*Methodology for Establishing Work RVUs* (pg. 32398)  
*Proposed Efficiency Adjustment* (pg.32399)

APA recognizes that psychiatry is among the few specialties projected to experience a small increase (1%) under the Efficiency Adjustment proposal. **While we welcome the exception of time-based services, E/M visits, care management services, behavioral health services, and services on the CMS telehealth list from the efficiency adjustment, we remain concerned about the approach being taken and potential repercussions. We also request that the following psychiatric services be removed from the list of codes subject to the efficiency adjustment as we believe they were added erroneously:** GPCM1, GPCM2, GPCM3, G0017, G0018, G2082, G2083, and 98000–98016.

- **GPCM1, GPCM2, and GPCM3**

APA requests that CMS exempt the Collaborative Care add-on codes for advanced primary care management (GPCM1, GPCM2, and GPCM3) from the proposed efficiency adjustment as they fall under the care management and behavioral health services exemption. These codes were developed to strengthen care management for patients with chronic conditions and reflect significant physician time, practice infrastructure, and clinical team resources. Applying the efficiency adjustment to these new services would undermine CMS' broader goals of improving care integration and advancing primary care transformation and could discourage uptake of these codes at the very time CMS is seeking to promote them.

- **G0017 and G0018**

APA also is asking CMS to remove HCPCS codes G0017 (*Psychotherapy for Crisis, first 60 minutes*) and G0018 (*Psychotherapy for crisis furnished in an applicable site of service; each additional 30 minutes*) from the proposed list of codes subject to the efficiency adjustment as they fall under the behavioral health services and time-based services exemptions. These services are explicitly time-based, and the proposed adjustment methodology, which assumes uniform efficiency gains across services, does not appropriately reflect this time-based reporting. Applying an efficiency adjustment to time-based codes risks under-valuing services where the physician's direct involvement and time commitment are the defining elements of the work. This could create unintended consequences for patient access and continuity of care, particularly in the context of providing individualized care for patients in acute psychiatric crisis.

- **G2082 and G2083**

APA requests that CMS exempt esketamine administration (HCPCS codes G2082 and G2083) from the proposed efficiency adjustment as both fall within the behavioral health services and time-based services exemptions. In the CY 2020 Physician Fee Schedule final rule, CMS recognized that esketamine services involve substantial physician and clinical staff time, as well as infrastructure costs to ensure patient safety and compliance with FDA Risk Evaluation and Mitigation Strategies (REMS) requirements. Based on these requirements, esketamine sessions require at least two hours of direct clinical staff supervision per patient, including observation in a dedicated treatment space and the immediate availability of a physician to manage potential adverse events, such as dissociation, sedation, and blood pressure changes. Adding G2082 and G2083 to the efficiency adjustment would arbitrarily reduce reimbursement for these already resource-intensive services, jeopardizing access for patients who rely on this service for treatment resistant depression.

- **98000–98016**

APA advises CMS to exempt Telemedicine Evaluation and Management (E/M) Services, CPT® code range 98000–98016 (98000, 98001, 98002, 98003, 98004, 98005, 98006, 98007, 98008, 98009, 98010, 98011, 98012, 98013, 98014, 98015, and 98016) from the proposed efficiency adjustment. These codes are established as E/M services and are inherently time-based, therefore they should fall under CMS’ proposed E/M and time-based exemptions. Applying the efficiency adjustment to this code set risks further undervaluing telemedicine E/M visits from their analogous office/outpatient E/M codes (CPT® 99202–99205, 99212–99215). Consistent with CMS’ intent to promote access and continuity of care, particularly for patients in rural and underserved areas, APA requests that these telemedicine E/M codes be excluded from the efficiency adjustment.

**Evaluation and Management (E/M) Visits** (*section II.F.*) (*pg. 32495*)

*Evaluation and Management (E/M) Visit Complexity Add-on* (*pg. 32495*)

**APA supports CMS’ proposal to allow G2211 (*Visit complexity inherent to evaluation and management*), to be billed as an add-on code with the home or residence E/M visits code family (CPT® 99341–99350). We also encourage CMS to review and adjust as appropriate their utilization assumptions regarding the billing of this code.** G2211 was initially expected to substantially increase Medicare spending based on estimates that it would be used 38-54% of the time when billing an evaluation and management service. However, a claims analysis by ECG Management Consultants of over 20,000 physicians found that only 5.2% of the eligible evaluation and management services billed included G2211, and only 36% of the physicians in the dataset billed the service, which is well below the initial projections.<sup>7</sup> As a result, these erroneous utilization assumptions caused an unwarranted reduction in the Medicare conversion factor due to budget-neutrality requirements which we ask CMS to correct.

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<sup>7</sup> Hayduk, M, and Taylor, K, G2211 One Year Later: Adoption, Impact, and What Comes Next, *ECG*. August 4, 2025. <https://www.ecgmc.com/insights/blog/g2211-one-year-later-adoption-impact-and-what-comes-next>.

**Enhanced Care Management** (section II.G.) (pg. 32496)

*Integrating Behavioral Health into Advanced Primary Care Management (APCM) (pg. 32549)*

*Behavioral Health Integration Add-On Codes for APCM (HCPCS codes GPCM1, GPCM2, GPCM3) (pg. 32501)*

*Valuation of Behavioral Health Integration Add-on Codes for APCM Services (Pg 32502)*

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

We ask CMS to consider the following recommendations as the new codes for CoCM in APCM are finalized:

- ***Increase Base Valuation*** - We continue to receive feedback from the provider community that the current rates for CoCM do not cover the costs of providing care. The overall low utilization of the CoCM codes (99492–99494) shows that practices are not currently implementing the model at the scale that is clinically indicated and economically desirable in part due to concerns about the risk of providing uncompensated care. This lack of adoption means that CMS will not be able to fully achieve its goals of primary care transformation or capitalize on CoCM's ability to reduce long-term costs. Blue Cross and Blue Shield of Michigan and Blue Cross North Carolina have recognized this concern and have supported implementation through enhanced payment rates set at 120% of Medicare for the CoCM code-set (99292–99294). **Therefore, we ask CMS to increase the base payment rates for the GPCM1 and GPCM2 codes to improve the ability for practices to cover the ongoing costs of providing this type of care.**

- ***Mechanisms to Address Complexity***

As described in the proposed rule, the existing time-based CoCM add-on code, CPT® 99494, does not make sense in the context of APCM. In our view, however, the clinical rationale for 99494 remains: the clinical case mix and associated service intensity of primary care patients with behavioral health needs can vary substantially. We are concerned that GPCM1 and GPCM2, which are designed to support a service-month of CoCM for the typical patient, will not adequately capture the time and resources required of the physicians and care manager to address the needs of the typical patient that falls within APCM G0557 (*beneficiaries with multiple (two or more) chronic conditions*) and APCM G0558 (*beneficiaries who are Qualified Medicare Beneficiaries with multiple (two or more) chronic conditions*). There are several ways this could be accomplished through the introduction of more codes (two codes per level of APCM), an add-on code or modifier to be billed in addition to the CoCM APCM codes. **Because CMS has taken steps to reduce the administrative burden associated with CoCM services we think the addition of two codes for each APCM level reflecting the increased complexity through differentiated payment**

**may be the simplest solution.** This automatic risk adjusted payment for CoCM based on the existing APCM level billed would help to account for the cost of providing care for the respective patient populations without adding any administratively burdensome billing and documentation requirements.

**We urge CMS to crosswalk the valuation to 99494 (*Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities*) with non-facility total RVUs of 1.84 and Facility total RVUs of 1.08 for APCM G0557 patients. Given the higher level of need of patients in G0558 we recommend CMS crosswalk the value of the payment adjustment to two 99494s.**

**We support and encourage policy steps that would enable wider uptake of CoCM, such as, training and technical assistance programs to help practices implement CoCM programs, mechanisms to cover the upfront costs of implementation (i.e., The COMPLETE Care Act) , as well as higher overall valuation of the CoCM billing codes, which would incentivize and reward providing CoCM to more of the patients for whom it is indicated and ensure sustainability of this cost-saving model.**

#### **APCM and Prevention Request for Information (pg. 32502)**

**APA requests that CMS eliminate beneficiary cost sharing for Advanced Primary Care Management (APCM) services.** We are concerned that any amount of cost sharing will be prohibitive and limit the uptake of APCM services, particularly among patients with chronic conditions and behavioral health needs who already face financial barriers to care. APA supports the position that APCM services should be treated as preventive services and therefore exempt from cost sharing. By design, APCM services incorporate systematic needs assessment, oversight of self-management, and coordination of care. These elements closely align with the preventive service elements of the “personalized prevention plan services” under section 1861(hhh)(1) of the Act. CMS has already recognized the importance of removing financial barriers to preventive care by waiving cost sharing for services such as Annual Wellness Visits and depression screenings. Waiving cost sharing would promote greater access, reduce patient burden, and encourage greater participation in APCM, thereby advancing CMS’ goals of strengthening primary care and prevention, improving outcomes for Medicare beneficiaries, and potentially leading to higher per capita savings over the long-term.

**Required patient cost-sharing can be a barrier to care, precluding individuals from engaging in models of care that have been shown to improve outcomes and reduce costs.<sup>8</sup>** While we understand the rationale for patient cost-sharing for services that may be at risk for overuse, based on the RAND Health Insurance Experiment, this rationale does not apply to services such as CoCM, general BHI, and indeed APCM, which are indicated for all patients in certain care settings who meet certain clinical criteria, and which are designed for the health system to furnish proactively (and often in ways that are invisible to the patient). **We support policies that would remove or reduce co-insurance for Medicare beneficiaries so that more individuals engage in treatments, such as APCM and CoCM, that have been shown to be effective and reduce long-term overall healthcare costs for Medicare.**

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<sup>8</sup> The Impact of Cost Sharing on High-Value Care. *Am J Manag Care*. March 2025. <https://www.ajmc.com/view/the-impact-of-cost-sharing-on-high-value-care>

There are similarities between CoCM and Screening, Brief Intervention and Referral to Treatment (SBIRT) (billing codes G0396, G0397, 99408 and 99409), a model of care that has been identified as a preventive service, as both include screening and brief interventions. **We propose CMS to work with appropriate stakeholders to classify CoCM, APCM and GCPM1 and GPCM2 services as preventive services and remove the cost sharing requirements, which for many patients is a barrier to care.**

Additionally, **we recommend that CMS ease relevant regulations to allow the behavioral health care manager to conduct the required patient consent process under the general supervision of the billing practitioner, including cost-sharing discussions and workflow explanations, rather than having this responsibility fall exclusively on the primary care physician (PCP). We request CMS not require re-consent when billing practitioners change within the same episode of care.** This approach would ensure patients remain fully informed while also reducing administrative burdens for PCPs.<sup>9</sup>

**Policies to Improve Care for Chronic Illness and Behavioral Health Needs** (section II.1) (pg. 32503)

*Updates to Payment for Digital Mental Health Treatment (DMHT) and Comment Solicitation on Payment Policy for Software as a Service (SaaS)* (pg. 32503)

APA reiterates our comments submitted previously regarding payment for digital mental health treatment (DMHT) devices. **There is insufficient evidence of efficacy for any of the DMHT devices currently on the market, including those with FDA approval, therefore we continue to disagree with paying for these devices. To date, there is no clear, practical definition of digital therapeutics that applies a rigorous standard of evidence of safety and effectiveness required prior to codifying reimbursement for these products.** Paying for these devices is premature and diverts Medicare funds that could be better allocated to support evidence-based treatments.

The FDA approval process must be improved to better evaluate DMHT devices. Real-world longitudinal data, statistically significant effect sizes, and studies using new research models are steps towards making FDA approval more meaningful. These devices are marketed as tools to increase access to care for everyone, and it is therefore imperative that these devices are studied at-scale and implemented within populations researched. In the few cases where these devices have been tested at-scale, concerns have been raised, such as increasing the risk of harm.<sup>10</sup>

APA emphasizes that:

- Digital therapeutics should not replace evidence-based clinical care.
- Digital therapeutics do not always consider key elements of digital equity including access to smartphones and adequate internet connectivity or data, digital literacy, and comfort with digital interventions, including privacy and security, and physical access to technology (e.g., for people with visual impairments).

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<sup>9</sup> McNutt C, Carlo AD. Mandatory Documented Consent and Cost-Sharing Impede Access to Collaborative Care Psychiatry. J Gen Intern Med. 2024 Feb;39(3):501. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10897089/>

<sup>10</sup> Torous J, Firth J, Goldberg SB. Digital Mental Health's Unstable Dichotomy—Wellness and Health. JAMA Psychiatry. 2024;81(6):539–540. <https://pubmed.ncbi.nlm.nih.gov/38630496/>

- Digital therapeutics or digital interventions need to be evaluated for the patient’s specific purposes in concert with the clinician to assess appropriateness for meeting the patient’s needs and should not replace clinical care.
- CMS should consider adopting a framework similar to the APA App Advisor Evaluation Model<sup>11</sup> in assessing the usage of apps in the Medicare population.

**Payment Policy for DMHT and Software as a Service Request for Information (SaaS) (pg. 32506)**

**On what reliable evidence do practitioners inform their clinical judgment that use of such digital tools is warranted or beneficial to their treatment of the patient?** As mentioned above, at present, the evidence base for most digital behavioral health tools, whether FDA-cleared or not, is limited. Randomized controlled trials are sparse, outcomes are often modest or inconsistent, and independent replication is rare. As a result, practitioners generally do not rely on a robust body of clinical evidence in making these judgments. Instead, decisions tend to be informed by individual patient circumstances, patient interest in using technology, anecdotal reports of benefit, and the practitioner’s assessment of whether the tool may help supplement traditional care. Importantly, such use is typically cautious, adjunctive, and accompanied by careful monitoring, rather than being based on reliable, broadly generalizable evidence.

**What role do these digital tools typically have within plans of behavioral health treatment?**

When used, digital tools most often serve as adjuncts to, not replacements for, evidence-based psychotherapies and pharmacologic treatments. Their role is generally supportive: providing psychoeducation, tracking symptoms, offering reminders, or extending access to self-management strategies outside of sessions. They may help engage patients between visits, but they are not yet integrated into most standard care pathways, nor are they central to treatment planning. In the absence of stronger evidence and more seamless clinical integration, their role remains supplementary and experimental rather than foundational.

**Payment policies for additional DMHT devices (pg. 32504)**

*FDA authorized eye-tracking technology and other technology to aid in the diagnosis of Autism Spectrum Disorder (ASD) in pediatric patients*

*FDA or granted De Novo authorization by the FDA, Digital therapy device for attention deficit hyperactivity disorder (ADHD).*

While promising, these technologies should be seen as adjuncts to, not replacements for, comprehensive psychiatric evaluation, which includes developmental history, caregiver input, and behavioral observation. Psychiatric expertise remains essential to interpret findings in the context of co-occurring conditions such as ADHD, anxiety, or intellectual disability. In addition, contractor-priced G codes must be structured to ensure equitable access across diverse practice settings. Without careful pricing and reimbursement strategies, there is a risk that only large health systems will be able to adopt these tools,

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<sup>11</sup> American Psychiatric Association. [APA App Advisor Evaluation Model](#)

leaving out community-based and underserved populations who may benefit most from earlier detection of autism spectrum disorders. Continued evaluation of these technologies is necessary to confirm their validity, generalizability across populations, and real-world impact on diagnostic accuracy, treatment initiation, and long-term outcomes. **APA encourages CMS to pair reimbursement with requirements for data collection to build the evidence base of their efficacy.**

#### **Prevention and Management of Chronic Disease Request for Information** (pg. 32507)

**APA supports the Administration’s focus towards supporting beneficial lifestyle changes, wellness, and disease prevention.** It is well-established that lifestyle factors play a key role in developing, preventing, and treating various physical and mental illnesses. Healthy lifestyle habits, such as a balanced diet, regular physical activity, restorative sleep, healthy stress management, strong connections, and avoiding harmful substances, can profoundly affect physical and mental health, enhancing quality of life and longevity. As such, psychiatrists routinely incorporate fostering these behaviors into treatment plan goals with their patients. Conversely, poor lifestyle choices can significantly deteriorate physical and mental health, exacerbate existing health issues, and reduce overall well-being.

**The Psychiatric Collaborative Care Model (CoCM) aligns with the Administration’s focus on better supporting prevention and management, including self-management, of chronic disease and improving wellbeing.** In this model, a care is provided by a primary care team consisting of a PCP and a health care manager who work in collaboration with a psychiatric consultant to address patients’ mental, physical, and social drivers of health. Other services, such as Community Health Integration (CHI) and Principal Illness Navigation (PIN), are aimed at improving access to behavioral health care by connecting patients with necessary clinical and social resources while addressing upstream drivers of health. **As such, CMS does not need to create separate coding and payment for intensive lifestyle interventions, but rather, prioritize CoCM services as they encompass many of the evidence-based prevention and wellness goals laid out in the Make America Healthy Again Commission.** Workflow changes should also be considered for any new coding proposals CMS develops as additional codes may increase administrative burden.

**Any proposals for prevention and management of chronic disease should incentivize and provide the financial sustainability for implementation of evidence-based models of care (e.g., measurement-based care [MBC], Psychiatric CoCM) shown to improve mental health and physical health outcomes in the primary care setting.**<sup>12</sup> Implementation of measurement-based care goes beyond screening and referral to improve care by employing repeated use of validated rating scales to serially assess symptoms over time and track clinical progress.

**APA does not recommend that CMS create separate coding and payment for motivational interviewing as it is a technique used by clinicians as part of an evaluation and management or psychotherapy visit.** Other health and behavioral health clinicians, such as care managers and auxiliary staff, use motivational interviewing with patients in settings such as Collaborative Care. We agree with CMS that this intervention should be furnished under the general supervision of the billing practitioner, ideally in a physician-led, team-based setting.

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<sup>12</sup> Wray LO, Oslin DW, Leong SH, et al. Enhancing Implementation of Measurement-Based Mental Health Care in Primary Care: A Mixed-Methods Study. *Psychiatric Services*. 2023;74(7):746-755. <https://psychiatryonline.org/doi/10.1176/appi.ps.20220140>

In 2024, the APA Board of Trustees approved the creation of a Presidential Workgroup on Lifestyle Psychiatry, charged with building psychiatry-focused, evidence-based educational content and would gladly serve as a resource for CMS as future proposals are developed. For instance, CMS could offer grants for organizations to create educational modules on the value of lifestyle interventions. The Presidential Workgroup recently published a comprehensive [report](#) reviewing the literature on the six pillars of lifestyle psychiatry: physical activity and exercise, nutrition, restorative sleep, stress management, toxic exposures, and connectedness. Lifestyle psychiatry is a burgeoning field of medicine rooted in evidence-based principles focused on helping individuals and families improve and sustain mental and physical health by adopting healthy lifestyle choices to optimize brain health.<sup>13,14</sup> This research provides an evidence base for research as requested by this RFI that addresses ways to improve health outcomes on an individual and population level to reduce the prevalence of mental illnesses and chronic diseases.<sup>15</sup>

**Technical Refinements to Revise Terminology for Services Related to Upstream Drivers of Health** (pg. 32510)

*Policies to Improve Care for Chronic Illness and Behavioral Health Needs* (pg. 32510)

Social Determinants of Health Risk Assessment (HCPCS code G0136) (pg. 32510)

**APA urges CMS to reconsider its approach to assessing social determinants or “upstream drivers” of health and proposed removal of the G0136 code for this service.** Research consistently demonstrates that external social circumstances, including challenges related to education, employment, and housing, have a strong influence on the patient’s overall mental health and well-being. Assessments of upstream drivers of health help clinicians understand this social context and address barriers beyond physical and behavioral health treatment, ultimately saving overall costs of treatment by improving overall health outcomes. This work is not currently captured within existing services so billing this in addition to other services would not be duplicative. CMS must continue to provide a mechanism to capture the work involved in behavioral health clinicians’ assessment of these critical upstream drivers of health.

**Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)** (section III.B.) (pg. 32547)

*Payment for Care Coordination Services* (pg. 32548)

*Integrating Behavioral Health Into Advanced Primary Care Management (APCM)* (pg. 32549)

**APA thanks CMS for its consideration of stakeholder feedback from the CY 2025 PFS final rule and recommends finalizing the proposal to allow FQHCs and RHCs to bill the Collaborative Care Management (CoCM) CPT® codes (99492-99494, G2214) in lieu of HCPCS code G0512 (*Rural health clinic or federally qualified health center (rhc/fqhc) only, psychiatric collaborative care model (psychiatric CoCm), 60 minutes or more of clinical staff time, per calendar month*).** This change will encourage greater adoption of CoCM in rural and underserved communities and help to reduce long-term costs. In addition, this proposal aligns with CMS’ efforts to integrate behavioral health services into advanced primary care models, ensuring that RHCs and FQHCs can sustain CoCM without billing restrictions that would otherwise

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<sup>13</sup> Merlo G, Fagundes C. Lifestyle Psychiatry: Through the Lens of Behavioral Medicine. 1st ed. CRC Press; 2023. 492 p.

<sup>14</sup> Merlo G, Ye W, Porter-Stransky KA: Lifestyle psychiatry for clinical care. *Psychiatr Annals* 2025; 55(7):e155-e159  
<https://psychiatryonline.org/doi/10.1176/appi.ajp.25182005>

<sup>15</sup> Merlo G, Baron D, Hirschberg A, Roy K, Smalls-Mantey A, Sugden SG, Porter-Stransky KA, Viswanathan R. American Psychiatric Association Lifestyle Psychiatry Presidential Workgroup Report. *Am J Psychiatry*. September 1, 2025;182(9).  
<https://www.psychiatryonline.org/doi/10.1176/appi.ajp.25182005>

limit access. APA appreciates this important step and thanks CMS for advancing policies that strengthen access to high-quality, integrated psychiatric care.

**Services Using Telecommunications Technology** (pg. 32555)

*Direct Supervision via Use of Two-way Audio/Video Communications Technology* (pg. 32556)

**We commend CMS for its continued commitment to supporting access to care by extending telehealth flexibilities for FQHCs and making virtual direct supervision permanently available.** These policies have been critical in expanding access to behavioral health and primary care, particularly for underserved populations. **However, we urge CMS to extend these flexibilities beyond FQHCs so that all providers and their patients may benefit from the same level of access and continuity of care.** Furthermore, CMS should make the broader telehealth flexibilities permanent, as temporary extensions create uncertainty and hinder long-term investment in virtual care infrastructure.

**Updates to the Quality Payment Program and Medicare Promoting Interoperability** (pg. 32695)

**APA urges CMS not to reduce the number of measures available for quality reporting.** CMS contends that decreasing the number of measures and MVPs will minimize burden; however, it is not the number of measures or MVPs per se that burden physicians. Rather, the burdens are related to the many reporting requirements, the frequent changes in requirements, the conflicts in requirements among different programs, and the complex data capture needed to obtain all elements of the requirements in a structured data format that is suitable for electronic reporting. This is especially relevant to non-primary care clinicians as they have limited measures that demonstrate quality in their specialties, yet Quality Payment Program proposals routinely recommend having all specialties report an increasing number of primary care-related measures, which is directly counter to MACRA and the QCDR concept.

**Transforming the Quality Payment Program** (pg. 32695)

*Query of Prescription Drug Monitoring Program (PDMP) Measure Request for Information* (pg. 32747)

**APA supports the broadest implementation of prescription drug monitoring programs (PDMPs) for effectiveness, but patient care, safety, privacy, and confidentiality must remain paramount in the implementation of any PDMP rules.** Because of the irregularities in state implementation of PDMPs, APA does not support changing the query of the PDMP measure from an attestation-based measure to a performance-based measure. **Moreover, APA does not support the expansion of the types of drugs to which the query of the PDMP measure could apply.**

As currently implemented, there is no interoperability across all PDMPs and, therefore, increased support in infrastructure and interoperability would be needed to see the intended outcomes of the measure. APA does support increasing infrastructure support and the establishment of best practices for PDMPs to improve their use among states, health systems, payers, and physicians in order to reduce prescription drug misuse, overdose, and death. Moreover, APA would generally support CMS' efforts to modernize the Promoting Interoperability program by aligning future measures with FHIR-based standards. A FHIR-based Prescription Drug Monitoring Program (PDMP) measure would better capture actual provider utilization and help accelerate integration into electronic health record workflows, thus reducing administrative burden and improving clinical decision-making.

Each state has varied laws and regulations that mandate different timeframes for reviewing the PDMP and varying rules about the types of professionals who have the ability to check the PDMP. An environmental scan of state-specific laws related to the PDMP may be needed prior to implementation of an updated measure to understand these challenges. We also note that PDMPs may have technical outages when a psychiatrist or other prescriber is trying to access the data and therefore access to the platform may be limited at times. There are also instances where patient data has been entered incorrectly, including the spelling of names, and therefore prescriptions are not listed. APA members also raised the concern that additional requirements could further limit the prescribing of medications for opioid use disorder. The broader intent of the proposed measure change is in line with reducing overdose deaths and continued interoperability. However, continued work and support to address barriers to implementation must happen prior to updating the measure. **CMS should continue to work with the ONC, DEA, and states to ensure that future PDMP-related measure updates account for this gap and that providers are not penalized for structural barriers beyond their control.**

**Fast Healthcare Interoperability Resources (FHIR) Request for Information** (pg. 32697)

- *What challenges providers and health information technology vendors anticipate during the transition.*
- *What guidance may be required from CMS to support the transition.*
- *Feedback on the stepwise approach to FHIR-based eCQM reporting.*
- *What challenges Accountable Care Organizations (ACOs) specifically have with reporting via FHIR, to include challenges about aggregated data.*
- *Any other implementation concerns.*

**APA recommends slowing the pace of rolling out these requirements and to take the necessary time to understand how existing measures will need to be retooled. We do not recommend focusing on retooling eCQMs as they currently exist as they will continue to be limited to EHR data.**

The hardest piece of reporting digital measures is getting the information from EHRs into a standardized computerized format, particularly because requirements are ever changing and every change in requirements means custom builds and changes in workflows (or hiring more people to enter data). Most practices are still at the stage of having to manually extract much of the data from the EHR and then enter or upload it. Further, many psychiatric facilities do not have much (if any) of the information in structured fields in an EHR.

**Therefore, CMS must simplify their processes and requirements.** The value from MIPS is minimal compared to the burden. Composite measures only add to the burden by increasing the reporting requirements while decreasing the credit granted.

**MIPS Cost Performance Category** (pg. 32697)

**APA supports the proposed modifications to the Total Per Capita Cost (TPCC) measure beginning in the CY 2026 performance period/2028 MIPS payment year.**

However, APA would like to stress once again that the Depression Cost Measure is less meaningful when not tied directly to quality measures or improvement activities. Depression, when treated early and effectively, will save money in the long run by reducing visits to the emergency department and/or hospitalization. Cost measures that focus more on identification and early intervention would serve psychiatry better than the existing measure.

**MVP Core Elements Request for Information** (pg. 32701)

***One of the key goals of Core Elements is to provide patients with enough information across different clinicians to compare specialist performance on foundational measures within a clinical area. Are there other ways to ensure MVP reporting results provide comparative performance data for patients on critical measures?***

APA does not support the concept of Core Elements. Limiting clinicians to core measures within a clinical area may not take into account sub-specialization and comparisons may not be appropriate. APA believes that the best way to provide meaningful performance information for both patients and physicians is to create separate MVPs for individual health conditions, episodes of care, and major procedures. A Depression Care MVP would tie Quality to Cost in a way that the current MVP cannot.

***Core Elements will be selected based on clinical relevance, but for consistency across MVPs, we are considering a set number of Core Elements for all MVPs. We are also considering setting the number of Core Elements in an MVP based on a percentage of the total number of quality measures in an MVP. For example, we may consider a policy that identifies 25 percent of an MVP's quality measures as Core Elements, such that an MVP with 12 quality measures would have three Core Elements measures to choose from. We request feedback on the ideal number or percentage of Core Elements in MVPs.***

CMS clarified on the AMA call in late August that the intent of the core elements is not to compare clinicians across specialties, which APA applauds. However, it does not seem feasible to set a required number of core element quality measures for every MVP, even if that is a percentage of the total. This concept of core elements limits choice, as not all measures apply to all clinicians in a broad specialty as defined by CMS. This may have the unintended consequence of having subspecialists report less meaningful measures.

***One of our concerns is that Core Elements specified for a few collection types, such as electronic clinical quality measures (eCQMs) or Qualified Clinical Data Registry (QCDR) measures, would limit clinician choice and may unintentionally force clinicians to report via intermediaries. One possible solution would be to include Core Elements with several different collection types, when possible, to provide clinicians with some choice of collection type. Are there other flexibilities or options that could reduce this limitation?***

APA supports making available multiple data collection types in MVPs. It is difficult for practices of any size to report eCQMs, and vendor-driven solutions are quite expensive. We encourage CMS to not only provide technical support but to motivate EHR vendors to provide straight forward solutions for reporting. Incentivizing practices for data collection/reporting would be the best way to get better data. Pushing EHR vendors to align with interoperability standards would be helpful.

***We are considering policies to increase the likelihood that clinicians have an applicable and available Core Element. We request feedback on ways to include measures that are applicable for more clinicians, such as including cross-cutting and broadly applicable measures. We also request feedback on ways to avoid disadvantaging clinicians without an applicable Core Element, such as attesting to no applicable and available Core Element.***

While including cross-cutting and broadly applicable measures might achieve CMS' aim of every clinician having a core element to report, it would be at the expense of meaningful data specific to varying psychiatric disorders. Choosing measures that are broadly applicable limits practices' ability to report measures that actually improve care for patients.

***We understand the Core Elements requirement places a new restriction on MVP reporting. We request feedback on whether the Core Elements reporting requirement would impact your decision to report an MVP while traditional MIPS remains a reporting option.***

The current Quality Care in Mental Health and Substance Use Disorders MVP does not include two of the most commonly reported measures by psychiatrists, Tobacco Use: Screening and Cessation Intervention, and Unhealthy Alcohol Use: Screening & Brief Counseling. As a result of this oversight, clinicians have been avoiding MVP reporting and will stay with traditional MIPS as long as possible. We encourage CMS to include these measures within the Quality Care in Mental Health and Substance Use Disorders MVP. Should Core Elements be finalized against most societies' wishes, we would request these 2 measures become Core Elements, along with Preventive Care and Screening: Screening for Depression and Follow-Up Plan.

#### **Medicare Procedural Codes Request for Information (pg. 32702)**

***We are considering utilizing Medicare procedural codes to further facilitate more MVP specialty reporting and to encourage and potentially require specialists to report an MVP applicable to their specialty or scope of care. Exploring approaches to utilize Medicare procedural billing codes for appropriately identifying MVPs relevant to a clinician specialty type could further increase MVP participation from MIPS eligible clinicians and groups.***

**APA does not support the assignment of clinicians to MVPs.** It is important that MVP participation remains voluntary and allows for choice. Assignment using procedural codes could place clinicians in an inappropriate MVP. For example, psychiatrists that bill only E/M codes and no psychotherapy codes may inadvertently be placed into a primary care MVP. If CMS decides to move forward with assignment, APA suggests that they use specialty codes and not procedure codes.

#### **Well-Being and Nutrition Measures Request for Information (pg. 32703)**

***We are seeking comments on tools and measures that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment. We would like to receive input and comments on the applicability of tools and constructs that assess for the integration of complementary and integrative health, skill building, and self-care. Please provide feedback on the relevant aspects of well-being for the QPP.***

APA supports the idea of assessing aspects of well-being; however, the lack of existing infrastructure (e.g., relevant measure, EHRs that collect data specific to psychiatry, and IT support) is a barrier, and more support and funding is needed for this assessment to become universal. The existing structure of data collection has done little to improve healthcare quality or patient outcomes in mental health.

PROMIS® tools already exist and measure many of the things listed above. Studies have extensively evaluated and determined that Social Drivers of Health are directly connected to well-being and nutrition, therefore adding well-being and nutrition measures while removing SDOH measures is counterproductive.

In the serious mental illness (SMI) population, the incorporation of social skills training is crucial to improving quality of life and well-being.

Investment by CMS in further development of measures around functioning and inclusion of existing measures of function in pilots of new payment models (and not just research) would be critical in moving these ideas forward.

#### **Data Standardization for Quality Measurement and Reporting** (pg. 32712)

Below is our feedback on CMS' request for information:

- ***Can you share any experiences or challenges reviewing, implementing, or testing the QI-Core, DEQM, or Bulk FHIR standards, including any experiences or challenges unique to Bulk FHIR Import versus Bulk FHIR Export?***
- ***Are there any deficiencies or gaps in the DEQM IG that must be addressed before it can potentially be used for reporting to CMS on eQMs using FHIR APIs?***
- ***Are there additional baseline requirements or capabilities that need to be considered before FHIR-based eQMs could be reported to CMS using Bulk FHIR?***
- ***Are there additional supports or enhancements that CMS should consider for the QI Core, DEQM, or Bulk FHIR IGs that would support quality measurement and reporting beyond the CMS eQMs or potential dQMs?***

Healthcare systems are still considerably far from being truly FHIR interoperable, despite the many ONC rules and regulations of the past few years. The typical psychiatric practice does not have the capacity to move to FHIR reporting without a lot of manual data entry or mapping. Mapping from various EHRs to FHIR standards is not robust and this adds significant burden. Vendors that are not cloud-based cannot update fields to be FHIR standardized, so it takes a significant amount of time by the healthcare system to map the existing fields—which have often been customized to meet state or other reporting requirements—to FHIR standards. Many psychiatric practices are solo or very small, without IT support, and if they have an EHR it is often without CEHRT. Additional financial support from CMS would be helpful to facilitate this implementation.

### High Priority Measure Definition- removal of health equity from the definition (pg. 32715)

**APA does not support removing health equity from the definition of high-priority measures.** While efforts to improve overall healthcare quality for all beneficiaries should be a goal, they do not address the fact that some groups of patients (individuals with serious mental illness or disabled individuals) experience substantial health inequities, independent of their race/ethnicity/gender.

Minorities face additional challenges in receiving care and may suffer from higher rates of mental health disorders. Disparities were not only related to the pandemic, though certainly the pandemic both highlighted and exacerbated enduring disparities in minority populations. It should still be a high priority to ensure we strive to offer quality care for those at greatest risk.

### Proposal to Adopt a Two-Year Informational-Only Feedback Period for New MIPS Cost Measures (pg. 32719)

APA supports the proposal to adopt an informational-only feedback period for newly implemented MIPS cost measures and **requests that this be made retroactive to 2024 implementation of episode-based cost measures.** We ask CMS to extend the informational-only feedback time frame to at least 3 years as 2 years may not be long enough. The current process does not allow clinicians to make changes that impact their cost scores in anything close to real time. As currently constructed, clinicians receive feedback on the prior year's reporting in late summer or early fall, which is too late to make changes that would improve the quality of care for the current reporting period. For example, it has been 8 months since 2024 ended with no data released. Clinicians have no feedback on how they scored on these new cost measures for last year, with only 4 months of the current year remaining and likely too little time to make any changes for 2025. Making the 2024 and 2025 data informational only now would provide an opportunity to understand scores and implement changes in practice patterns for 2026. **We support making this policy retroactive but, if that is not possible, we request that feedback be provided as soon as possible for the prior year's performance and a snapshot of current (2025) performance be provided for all cost measures on which they might be scored.**

### Proposals To Update the Improvement Activities Inventory (pg. 32723)

APA does not support removal of the Achieving Health Equity subcategory. Healthcare disparities are very real and ensuring that minority and populations with serious mental illness or disabilities receive quality care is important to all healthcare, but especially to psychiatry.

### Data Quality Request for Information (pg. 32753)

***What data quality challenges does your health care organization experience (for example, discrepancies in data accuracy, completeness, reliability, and consistency)? How are you working to address data quality challenges? What data quality challenges persist longitudinally across your patient population(s)?***

It is challenging to ensure that the appropriate diagnostic measures are implemented after a patient screens positive via a screening tool. Some practices are putting full stops in their EHRs to ensure required

measures are completed, but this is not a seamless process and requires work from the practice for it to happen.

***What are the primary barriers to collecting high-quality data? What resources do you believe could help your organization address these challenges?***

Virtually all data in psychiatry is patient reported; encouraging and incentivizing appropriate measurement at relevant encounters with a valid tool would go a long way to ensuring data is collected for all patients. Also working to improve the patient portals in EHRs would make it easier to collect the data.

***What steps should CMS consider to drive further improvement in the quality and usability of health information being exchanged? How can CMS partner with MIPS eligible clinicians, industry, and Federal agencies to drive further improvements in the quality and usability of health information being exchanged? What methods should CMS and other partners explore to further rectify data quality issues in the health care community?***

CMS should increase reimbursement for measurement-based care in fee for service payment, as this is critical for behavioral health and would improve the quality of the data.

Incentives are needed to offset the costs involved in data collection and reporting. CMS should eliminate (or greatly reduce) the various burdensome requirements, and design measures based on what is useful but also feasible and reasonable to collect (even if not “perfect” from a measures standpoint). Vendors would then be better able to meet the clinicians’ needs at less cost. CMS could incentivize EHR vendors to make this process easier and less costly. CMS needs to truly understand where the administrative burden lies and reduce burdensome requirements.

**Table Group C: Previously Finalized Quality Measures Proposed for Removal for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (pg. 33131)**

**APA does not support removal of the Screening for Social Drivers of Health nor the Connection to a Community Service Provider measures.** APA is concerned that the removal of these measures will mean that the remaining measures could unintentionally increase healthcare disparities. Social Drivers of Health (SDOH) are substantial contributors to the need for mental health services.<sup>iv</sup> Engaging community resources for those who have an identified lack of housing, food access, transportation, and medication access, will have a direct impact on improving mental health and access to care, which in turn will result in lower long-term healthcare costs.<sup>v</sup> The Make America Healthy Again campaign states “It shall be the policy of the Federal Government to aggressively combat the critical health challenges facing our citizens, including the rising rates of mental health disorders, obesity, diabetes, and other chronic diseases.”<sup>vi</sup> Identifying SDOH through screening will help psychiatrists develop a comprehensive treatment plan integrating social support services and addressing SDOH in ways that are tailored to an individual’s needs and preferences. With the provision of a whole-person treatment plan, care is more likely to be sustained and result in improved outcomes. Any measure of well-being is highly influenced by SDOH; holistic patient assessment is important and must include all relevant aspects of the patient’s life.

Thank you for the opportunity to provide comments. We look forward to working with you on continuous improvement of quality care for people with mental health and substance use disorders. Please contact Becky Yowell ([qualityandpayment@psych.org](mailto:qualityandpayment@psych.org)) with any questions or for more information.

Sincerely,



M.D., M.B.A., F.A.P.A.

Marketa Wills, MD, MBA, FAPA  
CEO and Medical Director  
American Psychiatric Association

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<sup>i</sup> Substance Abuse and Mental Health Services Administration. Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. Report No. HHS Publication No. PEP22-07-01-005, NSDUH Series H-57. <https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf>

<sup>ii</sup> Abramson, B., Boerma, H., Tsyvinski, A. Macroeconomics of Mental Health. *National Bureau of Economic Research*. April 2024. [https://www.nber.org/system/files/working\\_papers/w32354/w32354.pdf](https://www.nber.org/system/files/working_papers/w32354/w32354.pdf)

<sup>iii</sup> Jeffrey L. Goodie, Dana Stegelin, and Mary A. Drury, "Mental Health in the Primary Care Setting: A Primer," *Focus* 18, no. 2 (April 2020): 116–124, <https://doi.org/10.1176/appi.focus.20190028>

<sup>iv</sup> Kirkbride JB, Anglin DM, Colman I, Dykxhoorn J, Jones PB, Patalay P, Pitman A, Sonesson E, Steare T, Wright T, Griffiths SL. The social determinants of mental health and disorder: evidence, prevention and recommendations. *World Psychiatry*. 2024 Feb;23(1):58-90. <https://pubmed.ncbi.nlm.nih.gov/38214615/>

<sup>v</sup> Whitman A, De Lew N, Chappel A, Aysola V, Zuckerman R, Sommers BD. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. ASPE Report April 2022. HP-2022-12. <https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf>.

<sup>vi</sup> White House. Establishing the President's Make America Healthy Again Commission. February 2025. <https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/>.