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September 15, 2025

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
File Code CMS-1834-P
Baltimore, MD 21244–8010

CMS-1834-P; Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency

Dear Administrator Oz:

The American Psychiatric Association (APA), the national medical specialty society representing more than 39,200 psychiatric physicians and their patients, welcomes the opportunity to comment on the hospital outpatient prospective payment system and quality reporting programs.

We appreciate the Administration's commitment to supporting our nation's mental health through increasing service capacity, connecting more people with care, and promoting an environment that supports health and mental health. Our comments focus on supporting evidence-based treatment for mental health and substance use disorders through coverage and reimbursement while ensuring proposed quality measures are meaningful.

New Technology Ambulatory Payment Classification (APCs) (pg. 33537)

Depression is common with as many as one-third of people with depression considered treatment resistant, which is defined as those individuals who have not found relief from symptoms of depression even after trying several antidepressants. Esketamine provision (G2082 and G2083) and Transcranial Magnetic Stimulation (TMS), including SAINT Neuromodulation System's repetitive transcranial stimulation (rTMS) (0889T, 0890T, 0891T and 0892T), expand the treatment options available to patients with treatment resistant depression beyond traditional interventions, and allow psychiatrists to consider a wider range of treatment options tailored to patients and their response to treatment. Medicare beneficiaries should have access to all of the treatment options that can improve their condition and reduce long-term costs of untreated or undertreated illness.

The APA is concerned that the New Technology APC rates for these critical interventions are insufficient to cover the costs of providing these interventions, which will significantly limit the ability for patients with treatment resistant depression to access care that has been shown safe and effective.

SAINT Neuromodulation System (APCs 1511, 1521, 1522, and 1525) (pg. 33558)

Hospital outpatient settings are well positioned to provide SAINT Neuromodulation System's rTMS (0889T, 0890T, 0891T and 0892T), however APCs 1521 and 1522 do not adequately reflect the resources required to perform these services (0890T and 0891T) in that setting. Inadequate payments could affect the financial viability of providing these service in the hospital outpatient setting and therefore limit or even eliminate the availability of this intervention for Medicare beneficiaries. **We ask CMS to maintain the current New Technology APC assignments for rTMS (0889T, 0890T, 0891T and 0892T) for all services, including the assignments for 0890T and 0891T which are proposed to be lowered.** These assignments more appropriately reflect the resources required to perform the interventions and ensure access to evidence-based care until adoption of the procedures has grown and additional data becomes available.

Supervised Visits for Esketamine Self-Administration (APCs 1512 and 1517) (pg. 33555)

APA requests that CMS reconsider its proposal to reassign G2082 from APC 1513 (New Technology—Level 13) with a CY 2025 payment rate of $1,150.50 to APC 1512 (New Technology—Level 12) with a proposed CY 2026 payment rate of $1,050.50. Our members have expressed concern that current payment does not cover their costs for administering esketamine treatment to patients; further cuts would negatively impact the sustainability of the treatment. Esketamine treatment requires on-site, direct supervision with at least two hours of post-administration observation, vital-sign monitoring, documentation, and discharge assessment in a certified setting. These steps require fixed room time, dedicated nursing and physician oversight, safety supplies and equipment, and FDA Risk Evaluation and Mitigation Strategies (REMS) requirements compliance. A lower APC reassignment risks underpaying the true resource costs of these supervised visits, costs that continue to increase over time. Underpayment will disproportionately affect safety-net and rural hospitals and could impede timely access for patients with treatment resistant depression. Medicare beneficiaries, who typically better tolerate the lower doses of medication (56 mg or less), will bear the brunt of these proposed changes if less providers offer this treatment option. **We urge CMS to maintain G2082 in APC 1513 for CY 2026 to preserve access to this evidence-based care while additional cost data is collected.**

Additionally, we continue to believe the medical decision-making aspect of these services is undervalued. The codes currently include an Evaluation and Management (E/M) valuation equivalent to a 99212 (*office or other outpatient visit for the evaluation and management of an established patient…Usually the presenting problems(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family*) with straightforward medical decision making. We encourage CMS to increase the value of the E/M portion of the service to a 99213 (*office or other outpatient visit for the evaluation and management of an established patient…Usually the presenting problems(s) are of low to moderate severity. Typically, 20-29 minutes are spent face-to-face with the patient and/or family*) with low level of

medical decision making. This more appropriately reflects the work for the typical patient given the side effects and risks associated with the medication.

Finally, as noted in our comments on the CY2026 Physician Fee Schedule Proposed Rule, **APA requests that CMS remove HCPCS codes G2082 and G2083 from the proposed efficiency adjustment as both fall within the behavioral health services and time-based services exemptions.** These codes were added in error and inclusion in this list would arbitrarily reduce reimbursement for these treatments further.

Payment for Partial Hospitalization and Intensive Outpatient Services (pg. 33657)

APA opposes CMS' proposal to reimburse Community Mental Health Centers (CMHCs) for partial hospitalization programs (PHP) and intensive outpatient programs (IOP) at 40% of the rate for hospital-based PHP and IOP. PHPs serve an important role in the continuum of psychiatric care. PHPs meet the needs of patients who require comprehensive, highly structured, and multimodal treatments because their mental illness and/or substance use disorders severely interfere with multiple areas of daily life. Both patients who are transitioning out of inpatient hospital treatment and patients who may otherwise be at risk of inpatient hospitalization greatly benefit from this level of care.

IOPs have also been shown to be an effective model of care for individuals with mental health and/or substance use disorders who either require a higher level of care than standard outpatient services or a lower level of care than partial hospitalization services.[1,2] Because of the importance of maintaining access to this level of care and the significant impact Medicare policies governing the PHP benefit can have, CMS' proposals have important implications for psychiatrists and their patients.

We instead encourage CMS to adopt the same, or at least a similar, rate for PHPs and IOPs in CMHCs as compared to these programs when delivered in hospitals and other authorized settings of care. As CMS notes in this proposed rule, "the primary goal in developing the payment rate methodology for IOP and PHP services was to pay providers an appropriate amount relative to the patients' needs," in addition to avoiding cost inversions.[3] We believe this proposed rate is too low for CMHCs to effectively and appropriately staff and deliver their PHPs and IOPs, especially when the resources involved are comparable to those required for hospital-based programs. This could contribute to staffing shortages and ultimately limit access to care. As noted by CMS in this proposed rule, "We continue to believe that the costs associated with administering a partial hospitalization program represent the most resource intensive of all outpatient mental health services."[4] However, the estimated 0.6 percent increase in CY

[1] McCarty D, Braude L, Lyman DR, et al. Substance abuse intensive outpatient programs: assessing the evidence. *Psychiatr Serv*. 2014;65(6):718-726. https://pubmed.ncbi.nlm.nih.gov/24445620/

[2] Burton MS, Rothbaum BO, Rauch SAM. The role of depression in the maintenance of gains after a prolonged exposure intensive outpatient program for posttraumatic stress disorder. *Depress Anxiety*. 2022;39(4):315-322. https://pubmed.ncbi.nlm.nih.gov/35029316/

[3] Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems," 90 Fed. Reg. 33476, 33661 (proposed July 17, 2025).

[4] Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems," 90 Fed. Reg. 33497. (proposed July 17, 2025).

2026 payments to CMHCs relative to their CY 2025 payments based on the 40 percent rate fails to take this into account and is likely to be insufficient.

Paying a higher rate for these services in CMHCs would be a relatively small cost due to the fewer number of these programs with an outsized impact because it would simultaneously incentivize more CMHCs to deliver these services and effectively treat the unmet mental health needs of Medicare beneficiaries. We encourage CMS to develop a methodology that values CMHC PHP and IOP services at a higher rate than proposed that can also resolve the cost inversion issue in CMHC cost data, which resulted in higher geometric mean costs for 3-service days than for 4-service days.[5] Furthermore, paying for these programs helps to "prevent relapse or hospitalization," which is consistent with the statutory requirement and explicit Congressional intent of the Consolidated Appropriations Act of 2023.[6] As such, reimbursing CMHCs for these programs at the same or similar rate as hospitals would increase the number of programs delivering PHP and IOP in the community while ultimately reducing costs associated with preventable mental health- and substance use disorder-related hospital and emergency department services.

APA also recommends that CMS reassess and lift unnecessary compliance burdens from psychiatric facilities that do not improve patient care. The long-standing Conditions of Participation (COP) in CMS are required for an organization to bill to, and be reimbursed by, Medicare and Medicaid (Code of Federal Regulations, 42 CFR 482 Subpart E). These requirements include substantial administrative burdens that date back to the 1970s and are no longer relevant.[7] One example is the obligatory and time-consuming treatment plans, which are not required of any medical specialty other than psychiatry. They may have had relevance at a time when average length of stay was measured in months but are no longer applicable given today's shorter lengths of stay. Patient progress toward treatment goals is part of routine documentation in the medical record; an additional treatment plan is unnecessary. **We urge CMS to eliminate the requirement for a written treatment plan as defined in the Conditions of Participation and review other nonessential administrative requirements.**

Hospital Outpatient Quality Reporting (OQR) Program (pg. 33754)
Proposed Changes to the Hospital OQR Program Measure Set and Rural Emergency Hospital QR Program Measure Sets (pg. 33754)

APA does not support CMS' proposal to replace the existing Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients (Median Time for Discharged ED Patients) and the Left Without Being Seen measures with a new, multi-part measure: The Emergency Care Access & Timeliness eCQM. Replacing these separate measures with a complex, multi-part measure does not reduce burden and may make reporting more difficult, as tracking and ensuring all the data is properly compiled for a composite measure is more complicated than tracking separate numerators.

[5] *Id.*
[6] 42 U.S.C. 1395x(ff)(2).
[7] *The High Cost of Compliance: Assessing the Regulatory Burden on Inpatient Psychiatric Facilities* (Washington, DC: National Association for Behavioral Healthcare, March 19, 2019), Manatt Health, https://www.nabh.org/wp-content/uploads/2019/03/The-High-Cost-of-Compliance.pdf

If CMS moves forward with The Emergency Care Access & Timeliness eCQM, APA supports stratifying it by age and mental health disorder diagnoses. However, CMS states that "mental health diagnoses do not include substance use disorder diagnoses. Mental health refers to mental health diagnoses, life stressors and crises, and stress-related physical symptoms." Excluding substance use disorder diagnoses from the mental health strata and lumping them in with all other ED visits is not considered best practice. Substance use disorders are often co-morbid with mental health disorders and arguably, may be among the most difficult to treat cases in the emergency department. The data will be cleaner and more useful if all mental health diagnoses are included in the mental health disorders strata. **We urge CMS to include substance use disorders in the mental health disorders strata in calculating the eCQM.**

Proposed Removal of the Hospital Commitment to Health Equity (HCHE) Measure From the Hospital OQR and REHQR Programs and the Facility Commitment to Health Equity (FCHE) Measure From the ASCQR Program Beginning With the CY 2025 Reporting Period/CY 2027 Payment or Program Determination (pg. 33755)

CMS has additionally proposed removing the following measures related to health equity:

- Hospital Commitment to Health Equity (HCHE)/Facility Commitment to Health Equity (FCHE)
- Screening for Social Drivers of Health measure (Screening for SDOH)
- Screen Positive Rate for Social Drivers of Health measure (Screen Positive)

APA supports removal of the HCHE and FCHE measures as existing measures, such as The Joint Commission's National Patient Standard NPSG.16.01.01: Improving health care equity for the [organization's] patients is a quality and safety priority, serve the same purpose. Hospitals are already required to be compliant with this standard and we encourage CMS to align measures with existing standards. While APA supports reducing physician burden, we are concerned that the removal of all three of these measures will mean that the remaining measures focus too exclusively on diagnosed conditions at the expense of whole-person care and could unintentionally increase healthcare disparities.

We support maintaining the Screening for SDOH and Screen Positive measures because SDOH are substantial contributors to the need for mental health services and other chronic conditions.[8] Engaging community resources for those who have an identified lack of housing, food access, transportation, medication access, etc. will have a direct impact on improving mental health and access to care, which in turn will result in lower long-term healthcare costs.[9]

[8] Kirkbride JB, Anglin DM, Colman I, Dykxhoorn J, Jones PB, Patalay P, Pitman A, Soneson 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/

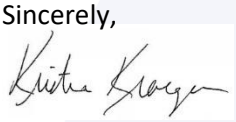
[9] Whitman A, De Lew N, Chappel A, Aysola V, Zuckerman R, Sommers BD. Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. ASPE Report April 2022. HP-2022-12. https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf.

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." [10] Identifying SDOH through screening will help us to develop a comprehensive treatment plan that integrates social support services and addresses 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.

SDOH commonly contribute to mental health crises, exacerbate other chronic health conditions, and complicate transitions from higher levels of care, making systematic screening for SDOH critical. By addressing issues such as housing instability, food insecurity, and trauma exposure, facilities can connect patients to community resources that reduce the risk of readmission and ED visits and support long-term recovery. The data on SDOH are also critical in determining accurate community resource needs. Furthermore, SDOH screening (and follow-up by connecting people to resources) is aligned with the recently stated Center for Medicare and Medicaid Innovation priority of promoting evidence-based prevention.[11]

Thank you for your review and consideration of these comments. We look forward to working with you on continue improvement of access to mental health care for Medicare beneficiaries. If you have questions or want to discuss these comments in more detail, please contact Becky Yowell (QualityandPayment@psych.org) Director, Reimbursement Policy and Quality.

Sincerely,



Kristin Kroeger
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[10] White House. Establishing the President's Make America Healthy Again Commission. February 13, 2025. https://www.whitehouse.gov/presidential-actions/2025/02/establishing-the-presidents-make-america-healthy-again-commission/.

[11] Center for Medicare and Medicaid Innovation. CMS Innovation Center Strategy to Make America Healthy Again. May 13, 2025. https://www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again