AMERICAN PSYCHIATRIC ASSOCIATION

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January 26, 2026

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
File Code CMS–4212–P
Baltimore, MD 21244–8010

Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program; CMS–4212–P

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 contract year 2027 policy and the technical changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and the Medicare Cost Plan Program.

Behavioral health burdens among Medicare beneficiaries remain high. Over 25% of the more than 66 million Medicare beneficiaries report having a mental health disorder.[1,2] Of the over 12 million beneficiaries eligible for both Medicare and Medicaid, half have a mental health condition, and many are individuals with lower incomes and/or those suffering from multiple health conditions.[3]

Funding for services to treat mental health disorders has historically lagged funding for physical health care with approximately 5-6% of total US health care expenditures allocated to mental health services in spite of the prevalence of these disorders[4] and research showing that increased investment in mental health services results in decreased costs related to emergency department visits, inpatient hospitalizations, as well as long-term cost savings associated with improved physical health. A 2024 RTI International report found that reimbursement rates for mental health services remain persistently low, with psychiatrists paid on average 11.5% less than primary care physicians and 26.1% less than medical/surgical specialist colleagues.[5] Meanwhile, underfunding the system has led to increased costs for beneficiaries (i.e., variable cost sharing/copays, out-of-network care) and coverage limitations (i.e., no or limited coverage for substance use disorders).

A 2023 Kaiser Family Foundation study[1] found that while Medicare Advantage (MA) plans cover the same mental health services as traditional Medicare, the cost sharing policies, use of prior authorization techniques, limited clinician networks, and lack of out-of-network coverage create barriers for patients trying to access necessary mental health care to the point that the MA plan is of limited benefit relative to a traditional Medicare plan. These limitations persist even when MA plans receive higher payments to cover the higher-than-expected cost of providing care to beneficiaries with higher risk adjustment factor scores. Barriers are also steep for beneficiaries with substance use disorders (SUD), who frequently face additional restrictions related to prior authorization, limited access to medication assisted treatment, and inadequate networks for intensive outpatient services or residential treatment levels of care. Several of our recommendations regarding the proposed rule will, if implemented, begin to address these barriers.

Medicare Advantage/Part C and Part D Prescription Drug Plan Quality Rating System (Star Ratings) *(§§422.164, 422.166, 423.186, and 423.184) (pg. 54964)*

APA appreciates CMS's ongoing efforts to improve the Part C and Part D Star Ratings system by focusing on improving clinical and other health outcomes. **APA supports CMS's proposal to add "Depression Screening and Follow-Up" as a new MA Star measure.** Given that suicide rates are increasing and rising faster in the older adult population than in any other age group,[2] it is vital that depression and other mental illnesses be identified and Medicare beneficiaries be connected to appropriate care in a timely way. Given the significant role mental health and substance use have in an individual's health and wellbeing, adding this measure will be consistent with CMS's goal of preventing and managing chronic disease and ensuring that MA enrollees have access to quality care.

APA strongly encourages CMS to add the "Initiation and Engagement of SUD Treatment" (IET) Star measure to Part C. Just like the "Depression Screening and Follow-Up" measure, IET is a measure in HEDIS® and in alignment with other federal reporting programs. Given the ongoing opioid public health emergency, it is now even more important that MA plans be transparent about SUD care.[3]

Adding, Updating, and Removing Measures (§§422.164 and 423.184) (pg. 54964)

APA opposes CMS's proposal to remove the Health Equity Index (HEI) reward and replace it with the historical reward factor. Research consistently shows that the Star Ratings system does not improve quality of care for all Medicare beneficiaries. The HEI reward provides an appropriate incentive for plan sponsors to level the playing field and invest in quality improvements for dually eligible, low-income, and disabled beneficiaries. By contrast, the historical reward factor is based on a plan's prior Star Ratings performance and is not tied to current quality improvement efforts, clinical outcomes, or patient

[1] Kaiser Family Foundation (2023, April28) "Mental Health and Substance Use Disorder Coverage in Medicare Advantage Plans". Mental Health and Substance Use Disorder Coverage in Medicare Advantage Plans | KFF

[2] Chloe Zilkha, Vani Agarwal, & Richard G. Frank, "Suicide Rates Are High And Rising Among Older Adults in the US," Health Affairs Forefront (Mar. 4, 2024), https://www.healthaffairs.org/content/forefront/suicide-rates-high-and-rising-among-older-adults-us.

[3] U.S. Department of Health & Human Services, Administration for Strategic Preparedness & Response, "Renewal of Determination that a Public Health Emergency Exists Nationwide as a Result of the Continued Consequences of the Opioid Crisis," ASPR (Dec. 15, 2025), https://aspr.hhs.gov/legal/PHE/Pages/Opioids-Renewal-15Dec2025.aspx.

experience, and does not incentivize investment in underserved populations. The historical reward factor is unlikely to drive changes in care delivery or address documented disparities because it rewards past performance rather than meaningful improvement or equity-focused action. There is ample evidence that MA plans are consistently denying patients needed care, both directly and indirectly.[4] **We urge CMS to allow plans to continue moving forward with the HEI investments made over the past several years in preparation for this reward system to go into effect.**

Improvements for Special Needs Plans *(pg. 54970)*
Request for Information: C–SNP and I–SNP Growth and Dually Eligible Individuals (pg. 54978)
Potential Policy Changes for Comment Solicitation (pg. 54983-54984)

We thank CMS for continuing to monitor and seek information on improving access to care for dually eligible individuals. APA shares CMS's interest in supporting improved access to treatment and care coordination for individuals with mental health conditions and/or SUDs, including those with serious mental illness (SMI). We appreciate the opportunity to comment on how special needs plans (SNPs) are serving this population and what improvements could be made to ensure individuals with these conditions are connected to appropriate services, especially given the higher rate of SUD in the SMI population.[5] **At a minimum, we recommend that CMS require plans serving a majority of dually eligible individuals be required to comply with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).** As noted below, **we strongly encourage CMS to require enhanced, parity-plus, MH/SUD benefits in C-SNPs (Chronic Special Needs Plans) and D-SNPs (Dual Special Needs Plans).**

Accordingly, to improve access to mental health and substance use care and overall health and wellbeing for dually eligible individuals, we urge CMS to **encourage Special Needs Plans to meet, at minimum, parity standards for mental health and substance use benefits and, preferably to exceed parity standards by offering enhanced mental health and substance use disorder care tailored to the specific needs of this population**. Further, plans that meet the functional definition of a D-SNP —including D-SNP "look-alike" plans that predominantly enroll dually eligible beneficiaries—should be held accountable for providing comparable levels of mental health and substance use benefits, care coordination, and beneficiary protections to prevent gaps in access and avoid undermining the purpose of the D-SNP program.

We are particularly concerned with recent research that shows dually eligible individuals (duals) enrolled in MA plans are receiving lower quality opioid use disorder (OUD) care than those enrolled in Medicare fee-for-service (FFS) plans, as well as individuals who have Medicaid only.[6] For example, duals in MA plans initiated substance use disorder treatment only 27% of the time compared to 44% of duals in Medicare FFS and 55% of Medicaid beneficiaries. Similarly, only 9% of duals in MA plans engaged in continued SUD

[4] Under-Diagnosed and Under-Covered: Claims Data Reveal Significant Medicare Gaps in SUD Treatment in 2020," Legal Action Center (Oct. 2024), https://www.lac.org/assets/files/RTI-Claims-Data-Issue-Brief-final.pdf.
[5] "Two Plans are Not Always Better Than One: Barriers to Substance Use Disorder Treatment for Dual-Eligible Individuals," Legal Action Center (Jan. 2024), https://www.lac.org/assets/files/Duals-Issue-Brief-2024.01.19_MAPP-Branded.pdf.
[6] Tami L. Mark et al., The Quality of Opioid Use Disorder Treatment in Medicare is Low and Lags Behind Medicaid," Health Affairs 44(9), 1086-1091 (Sept. 2, 2025), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00207.

treatment compared to 22% of duals in Medicare FFS and 30% of Medicaid beneficiaries. Finally, the rate at which individuals with OUD access medications for OUD (MOUD) – the gold standard of treatment for this condition – is also far worse for duals: only 17% in MA plans, compared to 30% in Medicare FFS and 57% of Medicaid beneficiaries.

We recognize that a significant part of the problem is Medicare's insufficient coverage of SUD treatment. Nonetheless, these MA plans are providing poor quality OUD treatment to the dually eligible population in the midst of the ongoing opioid public health emergency.[7] To address these deficiencies, CMS should require Medicare Advantage plans to cover and integrate evidence-based SUD services—including medication-assisted treatment, intensive outpatient care, and residential treatment—to help reduce administrative barriers and care fragmentation. Ensuring integrated coverage would allow care managers to connect dually eligible beneficiaries to appropriate services in a timely way, particularly during transitions in care. CMS should also require plans to clearly communicate the availability of SUD services to beneficiaries and caregivers through plan marketing materials and beneficiary communications.

Another underlying issue is that MA and Part D plans, including plans that serve dually eligible individuals, are not subject to MHPAEA. This is particularly problematic for dually eligible individuals though, because this population would have parity protections if they were enrolled in Medicaid managed care plans, rather than these Medicare plans. The lack of these protections may explain some of the disparities in the quality outcomes described above, as MA and Part D plans continue to impose disproportionate treatment limitations on SUD and MH care.

APA supports CMS's interest in improving access to treatment and care coordination for Medicare beneficiaries with mental health/substance use disorders who are enrolled in Medicare Advantage Plans. While there are costs associated with psychiatric care, it is well-established that improvement in mental health disorders leads to long-term cost avoidance through improved physical health, increased productivity, reduced disability, and lower incarceration rates.[8,9,10] As such, while the following recommendations are in response to CMS's request for information regarding SNPs, these recommendations should also be applied to Medicare Advantage more broadly.

APA recommends CMS strengthen plan design and benefits for mental health/substance use disorders, by requiring enhanced mental health benefits in SNPs. CMS should require SNPs, particularly C-SNPs and

[7] U.S. Department of Health & Human Services, Administration for Strategic Preparedness & Response, "Renewal of Determination that a Public Health Emergency Exists Nationwide as a Result of the Continued Consequences of the Opioid Crisis," ASPR (Dec. 15, 2025), https://aspr.hhs.gov/legal/PHE/Pages/Opioids-Renewal-15Dec2025.aspx.
[8] Melek, S. P., Norris, D. T., Paulus, J., Matthews, K., Weaver, A., & Davenport, S. (2018). Potential economic impact of integrated medical-behavioral healthcare.
[9] Davenport, S., Gray, T. J., & Melek, S. (2020). How do individuals with behavioral health conditions contribute to physical and total healthcare spending? Milliman, Inc.
[10] Government Accountability Office. (2019). Behavioral Health: Research on Health Care Costs of Untreated Conditions is Limited. (GAO Publication No. 19-274). Washington, D.C.: U.S. Government Printing Office.

D-SNPs, serving beneficiaries with severe or serious mental health needs to provide services beyond Traditional Medicare, tailoring benefits for this high-need population.[11]

Rather than focusing on medical necessity determinations through utilization management (UM) for all patients, **UM efforts should concentrate on patients with high clinical or psychosocial complex needs and aim to identify the service and care management requirements that will optimize the likelihood of improved outcomes including successful transitions from inpatient settings to community-based care. We recommend MA plans proactively provide targeted care management** for patients who experience frequent emergency department visits, frequent or prolonged inpatient stays, and/or have psychosocial needs such as homelessness. Implementation of population-based care principles, with care managers responsible for defined patient populations, would allow UM resources to be patient-centered, ensuring that patients' clinical and psychosocial needs are systematically identified and addressed.

CMS should ensure coverage and integration of SUD services to reduce fragmentation and barriers to evidence-based care (i.e., medication-assisted treatment, intensive outpatient SUD care, residential care) and highlight available services to Medicare beneficiaries.

APA recommends that CMS require Medicare Advantage plans to incentivize the use of evidence-based care management and patient engagement protocols for beneficiaries receiving mental health and substance use disorder treatment, including those with co-occurring chronic medical conditions. These protocols include proactive outreach following diagnosis or hospitalization, structured follow-up to support treatment adherence, coordination of services across care settings, and regular communication among patients, caregivers, and clinicians. Care managers play a central role in implementing these engagement strategies as connecting patients to community resources that address upstream drivers of health. Care management interventions have been shown to improve treatment adherence, continuity of care, and clinical outcomes across both behavioral health and chronic medical conditions.[12] Effective engagement in mental health and SUD treatment is also associated with reduced hospitalization and improved management of co-morbid physical health conditions.[13]

We recommend expanding supplemental benefits for those beneficiaries with serious mental illness or chronic mental illness to include additional care management/navigation programs, and prioritizing services such as transportation, in-home support services, and psychosocial education for patients and their families to address psychosocial needs central to recovery and adherence. Care management/navigation services could be beneficial in assisting beneficiaries in identifying what SNP works best for their individual needs, which could alleviate churn that occurs when beneficiaries switch plans after finding themselves in an MA plan that does not meet their needs. Research has shown that

[11] Offiaeli K, Meyers DJ, Macneal E, Johnston KJ, Brown-Podgorski B, Roberts ET. Patient-Reported Characteristics Across Dual-Eligible Medicare Advantage Plan Types. JAMA Network Open. 2025;8(4):e255791. Published 2025 Apr 1. doi:10.1001/jamanetworkopen.2025.5791

[12] Hernandez V, Nasser L, Do C, Lee WC. Healing the Whole: An International Review of the Collaborative Care Model between Primary Care and Psychiatry. *Healthcare (Basel)*. 2024;12(16):1679. Published 2024 Aug 22. doi:10.3390/healthcare12161679

[13] Schmidt EM, Wright D, Cherkasova E, Harris AHS, Trafton J. Evaluating and Improving Engagement in Care After High-Intensity Stays for Mental or Substance Use Disorders. *Psychiatr Serv*. 2022;73(1):18-25. doi:10.1176/appi.ps.202000287

dually eligible beneficiaries change MA plans at more than twice the rate of non–dually eligible beneficiaries.[14] Frequent disenrollment disrupts continuity of care and may signal inadequate access to services or poor quality within the plan. These disruptions are especially concerning for individuals with SMI, for whom continuity of providers, medications, and care coordination is critical. Moreover, dually eligible beneficiaries who disenroll are more likely to enroll in MA plans that are not subject to D-SNP care coordination requirements, such as D-SNP "look-alike" plans, further undermining access to integrated care.[15] Strengthening supplemental benefits and care navigation supports may reduce frequent plan disenrollment, promote continuity of complex needs.

APA encourages CMS to strengthen continuity-of-care protections for ongoing mental health and substance use disorder treatment, such as by extending Special Enrollment Periods (SEPs) and allowing retrospective enrollment for beneficiaries to regain their coverage if they experience unintended or adverse enrollment changes. We also support CMS's prior policy in the 2021 final rule to require plans and agents/brokers to clearly communicate to beneficiaries whether the event they are hosting is an educational event or a marketing event so that beneficiaries can be better informed of their plan options. These protections are increasingly important as enrollment barriers across Medicaid, Medicare Advantage, and exchange plans are expected to rise with implementation of eligibility provisions under H.R. 1, including work and community engagement requirements, more frequent redeterminations, and reduced eligibility for certain non-citizen residents. Frequent plan transitions disproportionately disrupt behavioral health treatment, including psychotherapy and medication-assisted treatment (MAT), where continuity of therapeutic relationships and medication regimens is critical. Existing continuity-of-care protections are not sufficiently tailored to mental health and substance use disorder treatment needs to ensure patients can maintain ongoing care during enrollment changes.

Removing barriers to care increases the likelihood that beneficiaries will engage in and remain in care. **We recommend that CMS encourage MA plans, including SNPs, to prioritize low or zero copayments for outpatient mental health services, including psychotherapy, psychiatric evaluation and management services, intensive outpatient care, care management services, and behavioral health integration services such as the Psychiatric Collaborative Care Model.** Encouraging low or zero copayments for mental health services would represent a meaningful, evidence-informed step toward improving outcomes for some of Medicare's most vulnerable beneficiaries. Low or zero cost sharing for mental health services is particularly critical for SNP enrollees. D-SNP beneficiaries disproportionately experience serious mental illness and face financial instability; even nominal copays can result in forgone care when Medicaid cost sharing is not fully coordinated. Removing financial barriers to mental health and substance use disorder care could incentivize C-SNP enrollees, including those with severe mental illness or multiple chronic conditions, to engage in MH/SUD treatment, which has a positive impact on both their mental health and overall physical health and has the potential to reduce overall long-term health care costs. Institutional Special Needs Plan (I-SNP) enrollees—who typically reside in long-term care facilities or

[14] Meyers DJ, Macneal E, Offiaeli K, Roberts ET. Enrollment in Dual-Eligible Special Needs Plans and Disenrollment Rates. JAMA Health Forum. 2025;6(7):e251748. Published 2025 Jul 3. doi:10.1001/jamahealthforum.2025.1748

[15] Ma Y, Frakt AB, Roberts ET, Johnston KJ, Phelan JF, Figueroa JF. *Rapid enrollment growth in "look-alike" dual-eligible special needs plans: A threat to integrated care. Health Affairs* 2023;42(7):919-927. doi:10.1377/hlthaff.2023.00103.

require an institutional level of care—often have complex medical, cognitive, and behavioral health needs. Consistent psychiatric oversight and care management services are critical for this population to support medication management, monitor behavioral symptoms, and prevent deterioration to reduce avoidable emergency department visits or inpatient hospitalizations.

APA urges CMS to strengthen behavioral health network adequacy requirements for SNPs. The CY 2025 Medicare Advantage Final Rule began to address network adequacy and equity concerns, including behavioral health access; however, persistent shortages of psychiatrists, psychologists, and licensed therapists and narrow networks, continue to limit access to appropriate care for high-need populations. SNPs, especially D-SNPs, serve beneficiaries with disproportionately high rates of mental health conditions, yet current standards do not reflect this elevated need. **APA recommends CMS adopt enhanced behavioral health network adequacy standards for SNPs, including shorter appointment wait times, stronger time-and-distance requirements, and minimum psychiatrists/therapists to beneficiary ratios. These standards should be more rigorous for D-SNPs, consistent with the population's higher behavioral health needs.**

Roughly 60% of patients seek help for mental health and substance use disorder treatment from their primary care physician. Although CMS requires SNPs to implement care coordination processes, behavioral health integration remains inconsistent and often superficial. Many SNPs continue to treat mental health and substance use services as parallel or carved-out functions rather than as core components of clinical care planning. **CMS should promote and incentivize evidence-based models of care such as the Psychiatric Collaborative Care Model (CoCM) and measurement-based care (MBC).** These practices have been shown to increase access, improve quality of care for both acute and chronic conditions, and reduce medical costs in both primary and specialty care,[16,17] results that should be important for all MA plans but especially C-SNPs and D-SNPs. CoCM in particular has been shown to not only improve outcomes but also physician and patient satisfaction.

A 2025 Milliman report highlighting the uptake of the Psychiatric Collaborative Care Model found that while overall adoption was highest in Medicare Advantage and lowest in Medicaid and CHIP, rates of adoption varied significantly based on geographic location.[18] This pattern suggests that Medicare Advantage plans recognize the clinical and long-term financial value of CoCM, though uneven implementation and geographic variation indicate the need for targeted policy incentives to support broader adoption. Policies enhancing payment rates, providing funds for up-front costs, or encouraging Medicaid payment could begin to close the gap in adoption. The Collaborative Care Model Heat Map developed by the Meadows Mental Health Policy Institute on behalf of Path Forward Coalition and in

[16] Bowman Family Foundation, Mounting Evidence That Use of the Collaborative Care Model Reduces Total Healthcare Costs, Second Edition (2025). https://www.filesbff.org/CoCM_Total_Healthcare_Costs_Issue_Brief.pdf.
[17] Carlo, A.D., Scott, K.S., McNutt, C. et al. Measurement-Based Care: A Practical Strategy Toward Improving Behavioral Health Through Primary Care. J Gen Intern Med 40, 677–681 (2025). https://doi.org/10.1007/s11606-024-08877-6.
[18] Davenport, S., Mager, M., & Darby, B. Trends in adoption of the Collaborative Care Model: Analysis of variation by payer and region, 2018–2023. Meadows Mental Health Policy Institute (2025). https://mmhpi.org/wp-content/uploads/2025/05/Milliman-Collaborative-Care-report-2025-05-13.pdf.

partnership with the APA, provides a data-driven tool that can inform CMS efforts to target payment, technical assistance, and policy levers to expand collaborative care in underserved regions. There are an emerging number of organizations infusing the core principles of CoCM into their workflows, such as population-based clinical management, use of measurement-based care to track progress, and a team-based approach with psychiatric and care management expertise to improve patient outcomes in the Medicare Advantage space that bear watching.

SNPs and Medicare Advantage plans in general, should remove any coverage barriers to telemental health services, including adopting Traditional Medicare's pay-parity policy, and paying the same rate regardless of what modality (in-person, audio/video, audio-only) is used to provide the care, including for evaluation and management services. Telehealth services, which have been shown to be as effective as in-person care, have increased access to psychiatric care, especially for individuals with disabilities or in remote or underserved areas, reducing appointment wait times and missed appointments.[19]

Rescinding the Annual Health Equity Analysis of Utilization Management Policies and Procedures *(§422.137(c)(5), (d)(6) and (d)(7)) (pg. 54988-54989)*

APA urges CMS to maintain the requirements for utilization management (UM) Committees to conduct an annual health equity analysis of the use of prior authorization. APA members report that MA plans frequently use prior authorizations to delay patient care. Determinations are made by plan employees who do not have expertise in mental health or substance use disorders and seem to be "reading off a checklist." Members estimate that the vast majority (as high as 80-90%) of the initial denials are overturned on appeal, making it appear that the initial decision was made to delay care. In the inpatient setting, delays in prior authorization decisions may increase the risk of hasty patient discharges which may lead to challenges in locating appropriate community care. The prior authorization process complicates and delays care in the emergency department setting where individuals seeking care are boarded while waiting for authorization. The chaotic and noisy emergency room setting is an environment that can further exacerbate acute symptoms and, in some cases, increases the potential for disruption or violence toward medical staff.

Request for Information on Future Directions in Medicare Advantage (Risk Adjustment, Quality Bonus Payments, and Well-Being and Nutrition) *(pg. 54991)*
Risk Adjustment RFI (pg. 54992)

We appreciate the opportunity to respond to CMS's RFI on risk adjustment using AI. As CMS considers updates to the risk adjustment framework, it should evaluate whether emerging tools can enhance accuracy and oversight without undermining transparency or fairness. **CMS should explore capitalizing on the use of artificial intelligence (AI) or other large language models and machine learning to support, not replace, risk adjustment.** AI tools could help improve the quality of diagnosis and encounter data,

[19] Bulkes NZ, Davis K, Kay B, Riemann BC. Comparing efficacy of telehealth to in-person mental health care in intensive-treatment-seeking adults. *J Psychiatr Res*. 2022;145:347-352. doi:10.1016/j.jpsychires.2021.11.003

spot unusual coding patterns, and flag when risk adjustment models need to adjust. AI could also help CMS find reasonable additions to the CMS's existing linear risk adjustment model, which relies on predefined diagnosis categories, additive coefficients, and limited interaction terms to predict expected costs. AI tools could help improve the quality of diagnosis and encounter data, spot unusual coding patterns, and flag when risk adjustment models need to adjust.

Moving from today's linear approach to AI could improve how well payments match expected costs and help CMS catch changes in coding behavior sooner, but it also brings real risks including the method for risk adjustment used becoming harder to explain, easier to "game," potentially by providers, health systems and others and more likely to create unfair results if the algorithm learns from biased data. Plans' best practices should include clear documentation, strong testing before use, regular checks ensuring results are similar across key groups, limits on using sensitive information or close substitutes, and independent review. AI can also help reduce fraud by identifying outliers and suspicious patterns for follow-up, but only if it is used to prioritize cases for human review and not to automatically deny payments or act without due process.

Additionally, security and privacy safeguards should include strong protections for protected health information, limiting access to only necessary data, maintaining audit logs of data and model access, and managing vendor risk through clear requirements and oversight. CMS and plans should also have clear policies that prevent training AI on data in ways that go beyond what beneficiaries would reasonably expect, or that could compromise their privacy.

Wellbeing and Nutrition RFI (pg. 54994)

APA supports the Administration's focus on 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 social connections, and avoiding harmful substances, profoundly affect physical and mental health, enhancing quality of life and longevity. As such, psychiatrists routinely incorporate these behaviors into treatment plan goals with their patients.

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. In addition to a recent report reviewing the literature on the six pillars of lifestyle psychiatry (physical activity and exercise, nutrition, restorative sleep, stress management, risky substances, and social connectedness), information related to this topic is available at Lifestyle to Support Mental Health. 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.[20,21] The report provides an evidence base that identifies ways to improve health outcomes on an individual and population level to reduce the prevalence of mental illnesses and chronic diseases.[22]

An additional policy that would "improve overall health, happiness, and satisfaction in life that could include aspects of emotional wellbeing, social connections, purpose, and fulfillment" is to **align MA and Cost Plan cost sharing for mental health and substance use disorder services with Traditional Medicare fee-for-service cost sharing, as CMS proposed in the CY26 MA proposed rule.[23] Access to affordable mental health and substance use disorder treatment is vital for overall health and emotional wellbeing, and we strongly urge CMS to adopt this policy.**

As CMS noted in that proposed rule, beneficiaries in Traditional Medicare pay only 20% coinsurance for all services (with zero cost sharing for opioid treatment program (OTP) services), while MA enrollees may be charged up to 50% coinsurance for the same mental health and substance use disorder services. CMS's data shows that approximately one in four MA plans have higher cost sharing for MH specialty and psychiatric services than Traditional Medicare, and individuals in these plans would save an average of $7 per visit under the proposed change. The potential impact for access to SUD services is even greater: more than two in five MA plans have higher cost sharing for outpatient SUD services than Traditional Medicare, and individuals in these plans would save an average of $30 per day under the proposed change. This means an individual enrolled in MA receiving outpatient SUD treatment just once a week would save over $1500 annually, and many individuals receive treatment more frequently.

Notably, 71% of MA plans have higher cost sharing for OTP services than Traditional Medicare, and individuals in these plans would save an average of $47 per visit. These costs add up quickly for individuals who attend treatment daily, as required for many participants, and these numbers show that many MA enrollees with SUD are currently spending thousands of dollars out-of-pocket annually to access this lifesaving SUD treatment.

While these additional costs would be minimal for MA and Cost Plans, these savings would be life-changing for Medicare beneficiaries with SUD and MH conditions. Among Medicare beneficiaries with SUD, one of the most commonly reported reasons for not receiving treatment was financial barriers.[24] Additionally, the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) found that Medicare beneficiaries with opioid use disorder (OUD) who receive the low-income subsidy are almost three times more likely (26% compared to 9%) to receive medications to treat their OUD than beneficiaries without the subsidy, identifying the high Part D cost sharing (averaging $268 annually for

[20] Merlo G, Fagundes C. Lifestyle Psychiatry: Through the Lens of Behavioral Medicine. 1st ed. CRC Press; 2023. 492 p.
[21] 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
[22] 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
[23] 89 Fed. Reg. 99340, 99401 (proposed Dec. 10, 2024).
[24] William J. Parish et al., "Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers," American Journal of Preventative Medicine 63(2), (Aug. 2022), https://www.sciencedirect.com/science/article/abs/pii/S0749379722001040.

those without the subsidy, compared to $19 annually for those with the subsidy) as a potential explanation for this disparity.[6]

We have heard from many treatment providers and advocates that Medicare beneficiaries with SUDs feel they must choose between their SUD treatment – which is currently more affordable through Traditional Medicare – and the other benefits that they might be able to receive through MA plans, such as vision, hearing, and dental. No one should be forced into this position, and we believe aligning cost sharing policies across Medicare plans will help ensure that those who choose to enroll in MA plans do not have to sacrifice their well-being or their mental health and substance use disorder care needs.

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) with any questions or for more information.

Sincerely,

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

[1] The term mental health disorders, includes substance use disorders
[2] U.S. Government Accountability Office, (Sept. 2024) Behavioral Health: Information on Cost-Sharing in Medicare and Medicare Advantage, https://www.gao.gov/assets/gao-24-106794.pdf.
[3]Kaiser Family Foundation, (2023, January) "A Profile of Medicare-Medicaid Enrollees (Dual Eligibles)," https://www.kff.org/medicare/issue-brief/a-profile-of-medicare-medicaid-enrollees-dual-eligibles/.
[4] National Institute of Mental Health (NIMH), (2023), Retrieved from www.nimh.nih.gov.
[5] Mark TL, Parish WJ. *Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue*. RTI International; April 17, 2024. https://dpjh8al9zd3a4.cloudfront.net/publication/behavioral-health-parity-pervasive-disparities-access-network-care-continue/fulltext.pdf.
[6] U.S. Department of Health & Human Services Office of Inspector General, "The Consistently Low Percentage of Medicare Enrollees Receiving Medication to Treat Their Opioid Use Disorder Remains a Concern," (Dec. 2023), https://oig.hhs.gov/oei/reports/OEI-02-23-00250.pdf.