AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024

June 9, 2025

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
File Code CMS-1833-P
Baltimore, MD 21244–8010

Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2026 Rates; Requirements for Quality Programs; and Other Policy Changes (CMS-1833-P)

Dear Administrator Oz,

The American Psychiatric Association (APA), the national medical specialty society representing over 39,000 psychiatric physicians and their patients, appreciates the opportunity to comment on the Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and Requirements for Quality Programs for FY 2026. Our comments focus on ensuring the sustainability of psychiatric inpatient care and issues related to quality improvement.

We encourage the Administration to consider ways to ensure the sustainability of psychiatric inpatient units, which provide medically necessary treatment for Americans with mental illness, including substance use disorders. Current reimbursement for inpatient psychiatric units fails to cover the full cost of providing care. These negative margins have contributed to the well-documented decline in the number of acute psychiatric inpatient beds over the past decade, delaying or impeding access to care for patients, including Medicare beneficiaries. This results in patients staying in emergency departments or being discharged prematurely. In worst-case scenarios, inaccessible treatment results in homelessness or involvement with the criminal justice system. If reimbursement rates for psychiatric hospitalizations continue to fail to cover the cost of delivering care, this level of care may cease to be available. **As CMS contemplates other refinements and regulatory relief, APA urges CMS to ensure that mechanisms are put in place to accurately capture costs (i.e., staffing, capital expenses, pharmaceuticals, emerging evidence-**

based interventions) now and in the future with as little administrative burden as possible. [1]

Extraordinary Circumstances Exception

APA supports the codification to grant an extension in response to an extraordinary circumstances exception request from a hospital in the Hospital IQR, Hospital Readmissions Reduction, PCHQR, HAC Reduction, and Hospital VBP Programs provided that each application is considered on a case-by-case basis and CMS recognizes that an extension is not always appropriate or feasible.

Measures Proposed for Removal

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

- 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 agrees that the FCHE measure is burdensome to report and not needed. The same purpose is served by 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. 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. Social Drivers of Health (SDOH) are substantial contributors to the need for mental health services and other chronic conditions[2]. 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[3]. The Make America Healthy Again campaign[4] 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." Identifying SDOH through screening will help us to develop a comprehensive treatment plan that integrates social support services and addresses SDOH in ways that

[1] 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

[2] 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. doi: 10.1002/wps.21160. PMID: 38214615; PMCID: PMC10786006.

[3] 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.

[4] 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/.

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 and exacerbate other chronic health conditions, and systematic screening for SDOH is 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 support long-term recovery. Data on SDOH are also important in determining community resource needs. Furthermore, SDOH screening and connection to resources is aligned with the recently stated Center for Medicare and Medicaid Innovation priority of promoting evidence-based prevention.[5]

CMS also states a preference for clinical outcome measures over structural measures or process measures as a reason for removing some of these measures. Although clinical outcome measures are ideal, many outcomes are not measurable in the one-year period that CMS currently mandates for the performance period. For example, APA developed a measure on recovery. This measure was not approved in the QPP program due to the long time period needed to show improvement between the index assessment and reassessment, which would have limited the number of patients to which it could apply. This would be even harder to achieve in this setting given the limited amount of time patients are hospitalized. **Structural measures and process measures demonstrate that systems are in place to help achieve improved long-term clinical outcomes and are not dependent on a patient's time in care, and APA recommends retaining Screening for SDOH, and the Screen Positive measures.**

RFI on Delirium Measures

APA generally supports the concept of a delirium screening measure for Long-term Care Hospital patients, as they may be prone to pneumonia and other causes of delirium. A measure that penalizes facilities for high rates of delirium, however, would be counterproductive as facilities could fail to under-identify delirium or refuse to take patients with prior delirium or those at highest risk of delirium. APA respectfully requests to be part of any delirium measure development process.

RFI Regarding the Query of Prescription Drug Monitoring Program (PDMP) Measure

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.**

[5] CMS.gov. CMS Innovation Center Strategy to Make America Healthy Again. 2025. https://www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again#:~:text=and%20CHIP%20programs.-,Promote%20Evidence%2DBased%20Prevention,new%20provider%20and%20beneficiary%20incentives.

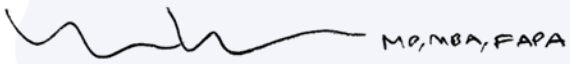
CMS notes that improved technology approaches and increased PDMP integration into electronic health record systems can increase utilization of PDMPs and the associated positive outcomes for patients. However, as currently implemented, there is no interoperability across all PDMPs and, therefore, increased 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.

Each state also has varied laws and regulations that mandate different timeframes for reviewing the PDMP and the professional that is able 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. 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.

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 illness, including substance use disorder. Please contact Becky Yowell (qualityandpayment@psych.org) with any questions or for more information.

Sincerely,



Marketa Wills, M.D., M.B.A.
CEO and Medical Director
American Psychiatric Association