January 16, 2026

Dear Members of the Doctors Caucuses,

Thank you for your ongoing efforts to encourage and drive Centers for Medicare and Medicaid Services (CMS) initiatives to support healthcare innovation and modernization. We appreciate the Caucuses' particular interest in Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) modernization and in strengthening the scalability of programs and pilots.

Mindful Choices for ADHD is the only nonpartisan, nonprofit organization created to inform national policy about ADHD. We bring together policymakers and advisors with leading clinicians, patients and medical innovators to address pressing challenges for individuals with ADHD and the healthcare system that serves them. In that context, we seek to work with the Doctors Caucuses on policy actions that we believe serve our common goals, which are to:

- *Mitigate overprescribing and potential misuse of higher-risk medications to ensure access to the right medications for ADHD patients for whom they are appropriate.*
- *Support innovation and commercialization of next-generation ADHD diagnostics.*
- *Address gaps in clinician education, especially relating to young adults with ADHD.*

Below, we offer additional context and recommendations for your consideration, which we hope will prompt an opportunity for further discussions with Caucus members and advisors as we seek opportunities to advance common goals.

I. Background

The neurodevelopmental condition referred to as Attention-Deficit/Hyperactivity Disorder (ADHD) impacts millions of Americans, affecting their productivity, time management, and emotional and behavior regulation, among other things. ADHD is also associated with comorbidities such as anxiety, depression, asthma, impulse control challenges, obesity and sleep disorders.

Unlike other neurological conditions, ADHD does not currently have a biomarker, which means that specialized clinical training and experience are necessary for a clinician to

make an accurate diagnosis. Yet clinical training in ADHD is not required to diagnose the condition or to prescribe medication for it. Regular overdiagnosis *and* under-diagnosis of the condition prevail thanks to public misperceptions, online misinformation, and a lack of formal training for most clinicians and prescribers. Not surprisingly, many individuals are improperly diagnosed with ADHD, and others who do have ADHD may not receive a diagnosis. This diagnostic crisis has given rise to a number of urgent challenges for the U.S. healthcare system, and of course for patients themselves. We raise two of these specifically for your consideration and hope to arrange a follow-up meeting to discuss these proposals in more detail.

II. Mitigating overprescribing and misuse of high-risk ADHD medications to ensure access to appropriate medications for all ADHD patients.

About one-third of U.S. adults are treated with ADHD stimulant medications, and the uptake of those medications has risen steadily.[1] From 2012 to 2022, prescription stimulant dispensing increased by almost 58%. Despite claims that children are the principal targets of over-prescribing, the most significant rise in prescriptions has been among adults.

Stimulants for the treatment of ADHD fall into two categories: extended-release (ER) and immediate-release (IR). Both types of ADHD stimulant medications use generally the same active ingredients, such as methylphenidate or amphetamine. They differ in terms of how fast the drug is released and how long it lasts in the body. Immediate-release formulations are significantly more likely to be misused or diverted because they act quickly, produce more noticeable short-term effects, and are easier to share/manipulate compared to extended-release versions.[2] According to treatment recommendations from the American Academy of Family Physicians National Research Network, stimulant medications may be used in adults with ADHD when clinically appropriate, and long-acting stimulant formulations are recommended for consideration in most patients due to evidence of effectiveness and reduced abuse and diversion risk relative to immediate release options.[3]

Misuse of IR prescription stimulants most often occurs among young adults and has been particularly acute and widely reported on college campuses, where students may have

[1] https://www.sciencedirect.com/science/article/pii/S1555415525001898
[2] https://pmc.ncbi.nlm.nih.gov/articles/PMC12434364/
[3] https://www.aafp.org/dam/AAFP/documents/patient_care/adhd_toolkit/adhd19-management-table1.pdf

easy access to medications from friends or classmates.[4] A common motivation for misuse is academic performance pressure, and this can be exacerbated by the prevailing sense of social acceptance stimulant misuse coupled with widely held misinformation that stimulant misuse is low risk. It is not. While there are appropriate uses of IR medications for people with clinical ADHD, ADHD specialists often recommend tighter prescribing controls on IR stimulants to reduce the risk of misuse and diversion.[5]

While most IR medications are old formulations and can be less costly, newer long-acting formulations that reflect more recent innovations can sometimes carry higher costs. Not surprisingly, many payers respond with utilization management approaches, including frequent prior authorization barriers that can stymie access to long-acting formulations that clinicians believe appropriate for their patients. These coverage barriers push both prescribers and patients to IR options more often than should be the case. (This reality also has created marketplace shortages in IR medications that have had adverse effects on patients who need them).

We urge Congress, and particularly leaders of the Doctors Caucuses, to direct CMMI to conduct a demonstration project to study the impact of eliminating prior authorization barriers in Medicaid and CHIP that hinder access to ER treatments for ADHD.

As Caucus members are aware, under Medicare, there are quantity restrictions that automatically apply at the pharmacy to limit the prescription amounts.[6] Medicare also allows step therapy at the drug choice level, enabling plans to require a patient trial of a drug from a preferred stimulant first (often generic IR or ER). Following that, prior authorization is typically applied when a drug is not on the preferred stimulant list, the dosage is higher, or the patient is outside of the typical age range. A prescriber is required to provide confirmation of diagnosis, clinical justification, and sometimes documentation of previous medication trials. Out of the three guardrails, prior authorization is the most burdensome and can result in delays in care/treatment disruption.

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[4] https://pmc.ncbi.nlm.nih.gov/articles/PMC8025926/; https://www.campusdrugprevention.gov/sites/default/files/2022-06/CPDS_Multi_Institutional_Key_Findings_2022.pdf

[5] https://www.sciencedirect.com/science/article/pii/S1555415525001898; https://pmc.ncbi.nlm.nih.gov/articles/PMC12434364/

[6] https://www.medicare.gov/health-drug-plans/part-d/what-drug-plans-cover/plan-rules; https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf

While these tools apply to many drug classes in Medicare Part D, ADHD stimulants are more likely to be subject to all three hurdles applied because they are Schedule II controlled substances, are used for long periods of time (and at different doses) and – as noted here – can be associated with misuse/diversion.

For ADHD diagnoses in the Medicaid/CHIP populations, prior authorization is currently used most often for children and adolescents, and for prescribing non-preferred stimulants or when the dose/quantity exceeds plan norms.[7] Some preferred drug lists and prior authorization requirements "nudge" prescribers toward IR stimulants over ER, mainly because IR generics are less expensive and/or older versions of drugs and often have to go through less hoops. As examples among many, on the Illinois Medicaid preferred drug list, methylphenidate immediate-release tablets are "Preferred," while the Aetna policy/guideline reflects that non-preferred stimulants are only approved after two covered alternatives have been tried and failed.

A CMMI voluntary Medicaid/CHIP demonstration program can not only bring down barriers like these to access ER ADHD stimulant medications but can also test whether removing prior authorization for ER ADHD medications encourages prescribing IR stimulants that are less likely to be misused or diverted. The pilot could be evaluated by tracking changes in uptake, assessing patient experience and adverse outcomes, and/or measuring supply shortages of IR therapies in state markets. These changes could mitigate inappropriate use and abuse and ensure access to the appropriate medications for ADHD patients.

III. Boosting diagnostic tools and addressing other ADHD clinical resource gaps

Because ADHD presents differently and sometimes uniquely by person – with nuanced distinctions between ages and genders, among other differentiators – diagnosing ADHD can be difficult. This is complicated further due to the prevalence of limited or inaccurate online misinformation about ADHD and a lack of objective diagnostic measures, and it leads to frequent misdiagnosis and an increase in (often inaccurate) self-diagnosis.

[7] https://phlr.temple.edu/news/2023/10/newly-updated-data-track-prior-authorization-medicaid-fee-service-plans-managed-care-plans

We encourage national policy leaders to promote innovation and modernization through these and other efforts:

- ***Drive broader adoption by clinicians of objective diagnostic tools, particularly next-generation innovations, to bolster accuracy.*** There is an important policy opportunity to support clinicians with proven, objective tools to improve diagnostic accuracy. We encourage Congress to support changes to the physician fee schedule (PFS) to enable physicians to bill for the use of existing and future diagnostic tools that meet certain criteria.

- ***Increase speed to market for innovative ADHD diagnostics, including but not limited to digital tools.*** As Congress considers upcoming modernizations to the Medical Device User Fee Act, we believe that prioritizing speed-to-market policy changes for diagnostics, particularly those for mental health conditions and those like ADHD that lack biomarkers. We urge Caucus members to take legislative action to reduce hurdles to market for ADHD diagnostics and create more predictable pathways to market for innovators. This can be accomplished by legislatively strengthening the FDA's capacity to review digital and AI-based diagnostic tools, as well as directing the publication of clearer guidance for emerging ADHD diagnostic technologies/tools, among other steps.

- ***Promote greater clinician training around ADHD, particularly in the primary care delivery system.*** Congress can encourage and direct additional clinician training, including through continuing medical education, for primary care practitioners and other prescribers. Based on national pharmacy dispensing data, roughly half of ADHD stimulant prescriptions dispensed in the U.S. came from primary care clinicians. Within this primary care prescriber group, nurse practitioners accounted for about 40% of ADHD stimulant prescriptions.[8] Policymakers can help address this information gap by promoting CME for nurse practitioners and other primary care prescribers, even by directing agencies like the Health Resources and Services Administration to fund and target this benefit for clinicians with higher-than-average ADHD therapeutic prescribers.

[8] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2813980

We hope that these recommendations address the needs and interests outlined in the RFI. On behalf of the national community of ADHD stakeholders, we thank you for the opportunity to provide comments in response to your RFI. We appreciate your consideration and interest in supporting the modernization of physician payment reform and look forward to opportunities where MCA can provide appropriate support for those efforts.

Respectfully,

Jakara Eason
Executive Director