June 16, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Assistant Secretary Thomas Keane, M.D.
Office of the National Coordinator for Health Information Technology (ONC), Assistant Secretary for Technology Policy (ASTP)
U.S. Department of Health and Human Services
330 C Street, SW, Floor 7
Washington, DC 20201

Re: Health Technology Ecosystem Request for Information, CMS-0042-NC

Dear Administrator Oz and Assistant Secretary Keane;

The Association for Behavioral Health and Wellness (ABHW) is pleased to respond to the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) Health Technology Ecosystem Request for Information (RFI).

ABHW is the national voice for payers managing behavioral health insurance benefits. Our member companies provide coverage to 200 million people in the public and private sectors to treat mental health (MH), substance use disorders (SUDs), and other behaviors that impact health and wellness.

Our organization aims to increase access, drive integration, support prevention, raise awareness, reduce stigma, and advance evidence-based treatment and quality outcomes. Furthermore, our policy work strives to ensure that physical and behavioral health care is integrated and coordinated. ABHW is focused on guaranteeing better outcomes for whole-person care for all individuals and communities. We believe access to comprehensive, evidence-based MH and SUD services is critical to enhancing patients' health and overall well-being.

Our members recognize the power of digital behavioral health solutions to expand care access, increase providers' efficiency, and provide patients with tailored, data-driven insights. However, the widespread adoption and integration of these solutions still have challenges related to interoperability, member engagement, and measuring the evidence base. As a result, we are advocating for the reforms below that will help foster collaboration between health insurers, providers, and technology developers. Some of these proposed changes are essential to fully realize the potential of digital behavioral health in improving care delivery and outcomes.

I. Incentivize Behavioral Provider Adoption of Technology

Behavioral health providers often lack access to the same technology tools that support coordination, quality, and efficiency in other areas of medicine, and were previously left out of incentive programs such as the American Recovery and Reinvestment Act of 2009's meaningful use program. Telehealth platforms, electronic health records (EHRs), data analytics, and care coordination tools can dramatically improve behavioral health outcomes—but only if providers are equipped and incentivized to use them. **ABHW supports initiatives to propel broader technology adoption among MH and SUD providers. For example, ABHW urges the federal government to provide behavioral health providers with health information technology (IT) incentive programs such as Medicare and Medicaid Promoting Interoperability.**

II. Interoperability, Data Access, and Patient Consent

Integrating digital tools into existing care models requires overcoming barriers such as interoperability to enable real-time data sharing across EHRs, telehealth platforms, and care management systems. Specific laws and regulations with complex and varying legal frameworks interrupt data sharing and interoperability.

42 CFR Part 2, or Part 2, is the federal regulation protecting SUD treatment records. Part 2 provides strict confidentiality protection for individuals receiving SUD treatment that is more stringent than what is protected under the Health Insurance Portability and Accountability Act (HIPAA). Part 2 limits the disclosure of SUD-related information and requires specific patient consent, even when sharing data among healthcare providers. For example, without explicit consent, a provider may not access a patient's digital screening results that suggest an SUD diagnosis. These protections are vital for building trust and encourage individuals to seek help without fear of stigma or legal consequences. Part 2's stricter consent rules make data sharing and full interoperability with behavioral health data difficult.

ABHW encourages the development of digital tools that can facilitate obtaining and managing patient consent in real time to facilitate compliant data sharing. ABHW also promotes the continued advancement of standards and systems that support tagging sensitive Part 2 data to ensure it is shared with the patient's explicit consent and applicable legal requirements.

III. Integrated Care

ABHW strongly advocates for integrated care, which combines behavioral health and physical health services to provide more comprehensive, coordinated, and patient-centered treatment. However, traditional integrated care models can face barriers: limited access to providers, fragmented systems, and inconsistent patient engagement. This is where virtual solutions can significantly enhance behavioral health care delivery.

We encourage the development of integrated care models that adopt interoperable and secure digital platforms that allow multidisciplinary teams to collaborate to enhance whole patient outcomes. For example, the Collaborative Care Model (CoCM) often uses digital platforms to coordinate between primary care physicians (PCPs), consulting psychiatrists, and care coordinators.

Digital behavioral health screening tools used in primary care settings significantly improve health outcomes by enhancing the early identification, diagnosis, and treatment of MH and SUD conditions.

Combining digital content with clinician-led care has shown signs of clinical effectiveness, particularly for depression.[1] **However, ABHW encourages continued development on expanding the evidence base for digital solutions by developing more comparative studies examining the long-term durability of clinical effects, effectiveness across diverse populations, and patient outcomes.**

The Innovation in Behavioral Health (IBH) Model is a structured, evidence-informed framework launched by CMS and the Center for Medicare and Medicaid Innovation (CMMI) that helps states integrate behavioral health into primary care, improving access, outcomes, and coordination. As of December 18, 2024, four states, Michigan, New York, Oklahoma, and South Carolina, have been selected to participate. It emphasizes team-based care, data-driven decision-making, and sustainable payment models. **ABHW supports consistent and continued funding for the IBH model, which includes expanding this model to new states. Increased and sustained funding to states for the IBH Model will support workforce development, infrastructure, and technology, and ensure that behavioral health is treated with the same priority and resourcing as physical health.**

IV. Digital Therapeutics

ABHW believes digital therapeutics are beneficial and can positively impact the treatment of MH and SUDs. Digital Mental Health Therapies (DMHTs) are a tool to eliminate gaps in behavioral health care by increasing efficiency and accessibility, addressing stigma, and helping support behavioral health provider shortages. Many ABHW members currently contract with DMHTs as they can help providers make more informed treatment decisions and improve patients' lives by offering better ways to manage their MH and SUD conditions.

Our member health plans continue to partner with digital behavioral health providers to enhance service delivery and manage costs. These partnerships aim to provide scalable, data-driven interventions that align with the shift towards outcomes-based reimbursement models, such as Value-Based Care. These digital tools can also be accessed from anywhere, reducing barriers for people in rural or underserved areas.

Medicare has taken a significant step by proposing reimbursement codes for digital mental health therapies, including apps and software, to treat behavioral health conditions in the 2025 Physician Fee Schedule. This move could set a precedent for private insurers, as Medicare could influence broader coverage trends. However, the proposed payment codes may initially apply only to a limited number of digital therapies.

The U.S. Federal Drug Administration (FDA) approval process for DMHTs needs to be improved to be more streamlined and efficient. DHMTs should be expected to demonstrate clinical effectiveness and consumer benefit before being considered for reimbursement. **ABHW supports advancing**

[1] https://phti.org/wp-content/uploads/sites/3/2025/05/PHTI-Virtual-Solutions-Depression-Anxiety-Assessment-Report.pdf

coverage for digital therapeutics and appreciates the need for guardrails around what should be covered. DMHTs should be considered for reimbursement after they are appropriately evaluated for clinical validity and practical benefit for the conditions or symptoms they are proven to address.

A common set of metrics for defining DMHT's clinical validity, engagement, and outcomes is needed. Some critical metrics are (1) evidence of medical appropriateness, (2) cost-effective, and (3) can be implemented effectively.

V. Transition to Value-Based Care

Advancing value-based care (VBC), the healthcare model that rewards outcomes over volume, requires specific technological improvements that enable more innovative data use, better provider collaboration, improved patient outcomes, and efficient payment models.

We encourage CMS to include behavioral health-specific measures in their programs and to incentivize behavioral health providers to report on those measures. Such measures could be included in NCQA's Healthcare Effectiveness Data (HEDIS) measure set and the Merit-based Incentive Payment System (MIPS) Program. For example, HEDIS and MIPS already include some behavioral health-specific metrics, such as follow-up after hospitalization for mental illness, depression screening, and follow-up planning. CMS could also consider encouraging measure developers and stakeholders to develop new measures in this space, particularly focused on outcomes.

VI. National Provider Directory

ABHW believes a national provider directory could help enhance accuracy and access to available providers. We recognize and support the need for accurate provider directories, particularly in light of the increasing demand for services and accompanying workforce shortages. Provider directories depend on timely and accurate data submissions from providers. Maintaining up-to-date, robust provider directories should be a shared responsibility of providers and health plans. Many behavioral health providers operate small businesses independently without staffing support. They often use their personal information to book appointments, making it difficult for health plans to monitor their office hours and availability.

To reduce the administrative burden on providers and streamline efforts, CMS's national database should be interoperable with other public and private databases, including private health insurer and group health plan directories, Medicare, Medicaid, states (e.g., licensing databases, and health agencies), and other data sources (e.g., CAQH, NPPES).

CMS should work to create a scheduled workflow to update the information in a predictable manner and eventually have an opportunity for automation. Ultimately, the database should harmonize with another database and have real-time updates that allow seamless system-to-system integration.

ABHW encourages CMS to have an initial verification mechanism to check data as it is entered. Health plans are not responsible for validating provider information. Perhaps, CMS could work with stakeholders to determine a private and secure option to request verification and attestation as an entry point. After the initial verification, there should be additional steps to revalidate the information provided.

If health insurance plans are participating in supporting CMS's national database, they should be deemed compliant with existing provider directory regulations.

Lastly, ABHW recommends that CMS incrementally build out the national directory. Developing a comprehensive, real-time national directory is a substantial undertaking that will require significant staff time, expertise, and coordination. We suggest CMS prioritize implementing the demographic data already required by the Consolidated Appropriation Act, 2021 (CAA), Section 116, which includes the names, addresses, specialties, telephone numbers, and digital contact information for healthcare providers and facilities.

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ABHW is ready to support CMS, ASTP, and this administration in encouraging and easing data exchange among the healthcare ecosystem for patients, providers, and health plans. We look forward to working with you to achieve the goal of improving all Americans' behavioral health. Please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org if you have any questions.

Sincerely,

Debbie Witchey, MHA
President and CEO