ABHW
Advancing Health Care Policy for
Mental Health & Substance Use Disorders

June 10, 2025

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

Re: CMS Unleashing Prosperity Through Deregulation of the Medicare Program Request for Information

Dear Administrator Oz;

The Association for Behavioral Health and Wellness (ABHW) looks forward to collaborating with the Centers for Medicare & Medicaid Services (CMS) to streamline regulatory requirements and improve access to behavioral health services. We have identified several areas within Medicare's behavioral health programs that require reform to enhance access and reduce administrative burden.

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 that access to comprehensive, evidence-based MH and SUD services is critical to enhance patients' health and overall well-being in Medicare.

To support your efforts, below are commonsense reforms that cut unnecessary red tape and expand access to behavioral health services in Medicare programs.

I. Network Adequacy

Certain network adequacy regulations limit Medicare Advantage (MA) plans' ability to design cost-efficient narrow network plans, curb differentiation, and stifle market innovation. Some provisions below add complex network adequacy requirements that don't account for the behavioral health workforce shortage and add administrative burden to business operations. Maintaining compliance with complex network adequacy standards increases business administrative overhead, diverting resources from consumer-focused improvements and competitive pricing.

1) Appointment Wait Time Standards: Rescind Guidance

In the April 2025 Final Letter to Issuers in the FFEs and April 2024 Appointment Wait Time Secret Shopper Survey Technique Guidance for Qualified Health Plan Issuers in the Federally-facilitated Exchanges, which include Medicare Advantage plans, CMS established specific 10-day wait time requirements for behavioral health services. Given current provider availability, these requirements are challenging to meet and could lead to compliance issues. **We request that CMS rescind this provision for the MA behavioral wait times.**

The administration should align wait times for behavioral health services with existing standards already applied in the industry, such as the National Committee for Quality Assurance (NCQA) standards, which are already standardized across provider types and will eliminate confusion among stakeholders – plans, providers, and patients. Additionally, at a minimum, CMS should implement a different timeframe for non-emergency behavioral health services, which should be fourteen days, versus the proposed one week. Given that emergency or urgent care is generally made available across the industry within 72 hours, there should be a more differentiated standard for non-urgent care. This seems warranted for non-emergency behavioral health, with the unprecedented demand for services and limitations in the system and workforce today.

2) **Prohibition on Dual-Listing Providers Across Specialties; Rescind Provision: 422.116(b)(2)**

In CMS's Contract Year 2025 Medicare Advantage and Part D Final Rule, CMS finalized a provision restricting a single provider from being counted in multiple network adequacy specialty categories. This increases the administrative burden without allowing providers to be valued for their specific expertise. For example, a provider cannot be counted in the psychiatry and outpatient behavioral health categories. This creates confusion for beneficiaries as they have less information about the specialties of particular providers. **ABHW requests that this requirement be eliminated.**

3) **Limited Telehealth Credit Towards Network Adequacy, Amend Provision § 422.116(d)(5)**

CMS finalized a provision in the 2025 Medicare Advantage and Part D Final Rule that offers only a 10-percentage-point credit for telehealth providers in meeting network adequacy standards, which does not sufficiently account for telehealth's role in expanding access. Telehealth has proven an effective way to expand access to high-quality care, particularly in behavioral health. The United States Department of Health and Human Services (HHS) and CMS have acknowledged the benefits of telehealth and should continue to evaluate ways to improve access, particularly in rural areas or areas with significant provider shortages. **Given the acute workforce challenges limiting the supply of behavioral health providers and the efficacy of delivering behavioral health services via telehealth, CMS should increase the telehealth credit above 10 and work with industry stakeholders to discuss an appropriate increase to the telehealth credit.**

4) **Minimum Patient Volume Requirements for Behavioral Health Providers: Rescind Provision § 422.116(b)(2)(xiv)(B)(1) and (2)**

A new requirement in the Contract Year 2025 Medicare Advantage and Part D Final Rule requires certain providers, including nurse practitioners (NP), physicians assistants (PA), and certified

nurse specialists (CNS), to treat a minimum number of patients before they can be included in network adequacy assessments, potentially excluding qualified providers. For an NP, PA, or CNS to satisfy the Outpatient Behavioral Health network adequacy standards, the NP, PA, and/or CNS must have furnished certain psychotherapy or SUD prescribing services to at least 20 patients within the previous 12 months. **We ask CMS to rescind the 20-patient requirement, as a provider should not have to prove they have served a minimum number of patients. By arbitrarily shutting certain providers out of networks, this requirement impedes access to services.**

II. Telehealth

ABHW supports expanding coverage for evidence-based telehealth services and removing unnecessary barriers to telehealth care delivery. We understand that CMS has limited authority and must defer to Congress to make telehealth flexibilities more permanent. Some current Medicare laws and regulations unnecessarily limit access to and coverage of telehealth services and should be permanently changed. In particular, **ABHW continues to advocate for Congress to remove the Consolidated Appropriations Act (CAA) of 2021 telehealth condition that requires Medicare beneficiaries to have an in-person visit within six months prior to receiving MH services via telehealth, and at other reasonable timeframes as determined by the Secretary.** This mandate will exacerbate healthcare disparities and impede access for rural populations, older adults, and low-income residents. A blanket requirement for in-person sessions may hinder access for those unable to travel for in-person care or those concerned about the stigma of receiving MH services.

III. National Provider Directory

ABHW believes a national provider directory could be helpful to enhance accuracy and, ultimately, access. 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 leverage existing initiatives, harmonize current regulations on provider directories across multiple federal programs, and invest additional funds to adopt scalable technology solutions under a federated model.

ABHW recommends that CMS engage all stakeholders, including health plans and providers, as developing a comprehensive, real-time national directory is a substantial undertaking that will require significant staff time, expertise, and coordination. We suggest that CMS prioritize implementing the demographic data already required by the CAA, Section 116, which includes the names, addresses, specialties, telephone numbers, and digital contact information for healthcare providers and facilities.

Conclusion

ABHW is ready to support CMS and this administration in ensuring that regulations reduce unnecessary complexity and safeguard fair access to MH and SUD services. We look forward to working with you to pursue the common 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