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

September 15, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2439-P
PO Box 8016, Baltimore, MD 21244-8016

Re: Medicare and Medicaid Programs; Calendar Year 2026 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Proposed Rule (CMS-1834-P)

Dear Administrator Oz:

The Association for Behavioral Health and Wellness (ABHW) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services (CMS) Notice of Proposed Rulemaking (NPRM or proposed rule) for the Medicare and Medicaid Programs: Calendar Year 2026 (CY 26) Hospital Outpatient Prospective Payment Systems (OPPS).

ABHW is the national voice for payers managing behavioral health insurance benefits. Our member companies provide coverage to 200 million people in both 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.

I. Intensive Outpatient Program and Partial Hospitalization Program

Intensive Outpatient Treatment (IOP) and Partial Hospitalization Programs (PHP) should be covered and reimbursed on a site-neutral basis to ensure patients can access the right level of care in the most clinically appropriate and cost-effective setting, as determined by the patient in consultation with their provider. Coverage for IOP and PHP should not be dictated by the physical location of the service or type of facility, whether delivered in a hospital, community clinic, or outpatient facility, but by the intensity and quality of care provided.

For IOP, which is a structured and evidence-based program of behavioral health services regardless of setting, the tying of payment to location rather than the actual treatment creates unnecessary barriers and costs for patients. Site-neutrality would streamline the coverage and reimbursement process and support community-based and lower-threshold care options that are often more accessible, efficient, and effective.

II. Access to Non-Opioid Treatments for Pain Relief

CMS is proposing to provide temporary additional payments for specific non-opioid treatments for pain relief furnished in Hospital Outpatient Department (HOPD) and Ambulatory Surgical Center (ASC) settings from January 1, 2025, through December 31, 2027, consistent with Section 4135 of the Consolidated Appropriations Act, 2023 (CAA, 2023), which directs CMS to ensure separate payment for non-opioid alternatives when they are furnished in outpatient surgical settings. Beginning in CY 2026, CMS proposes to pay separately for five proposed drugs and six devices identified as non-opioid pain management treatments in both the HOPD and ASC settings.

ABHW strongly supports the use and payment for non-opioid treatments as a necessary solution to combat the high rate of opioid use disorder. However, non-opioid pain treatments must be evidence-based and clinically appropriate as determined by the provider and the patient. ABHW members are cognizant that there is a lack of evidence that these drugs meaningfully reduce opioid use. While we recognize the statutory requirement for separate payment of non-opioid alternatives, we are concerned that manufacturers may be advancing products primarily to serve their own commercial interests. Therefore, the process for identifying and approving these drugs must be rigorous and transparent.

Currently, CMS's approval framework requires that drugs or biologics carry a Food and Drug Administration (FDA) approved label for reducing post-operative pain or producing post-surgical/regional analgesia without acting on opioid receptors. CMS defers to the FDA labeling. If the FDA-approved label matches the statutory language for post-operation pain control without opioid receptor activity, CMS considers that sufficient. General pain indications or off-label uses do not qualify.

ABHW is concerned that CMS's process does not adequately assess whether these drugs, in practice, reduce opioid utilization or mitigate the risk of opioid addiction. We believe additional scrutiny is needed to ensure that payment policies for non-opioid alternatives are consistent with the overarching goal of reducing opioid dependence and improving patient outcomes.

III. Request for Information on Streamlining Regulations and Reducing Administrative Burdens in Medicare

We have identified several areas within Medicare's behavioral health programs that require reform to enhance access and reduce administrative burden regarding network adequacy. We have shared some provisions below, but please see more details in

ABHW's June response to CMS's Request for Information on Unleashing Prosperity Through Deregulation of the Medicare Program.

Specific network adequacy regulations limit Medicare Advantage (MA) plans' ability to design cost-efficient narrow network plans, curb differentiation, and stifle market innovation. The 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. Since 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. Providers cannot be counted in the psychiatry and outpatient behavioral health categories. For example, an internist providing primary care cannot be counted as providing outpatient behavioral health even though data suggest that many individuals receive outpatient behavioral health care from primary care doctors such as internists. 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 (PAs), and certified nurse specialists (CNSs), 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 specific 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 providers 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.**

Thank you for the opportunity to comment on the behavioral health provisions in the CY26 OPPS. ABHW is committed to working with CMS and other partners to improve access to behavioral health treatment for all Americans. If you have any questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,

Debbie Witchey, MHA
President and CEO