November 10, 2025

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

Re: Recommendations to CMS for Behavioral Health Priorities within the Medicaid Rural Health Transformation Fund

Dear Administrator Oz:

The Association for Behavioral Health and Wellness (ABHW) respectfully submits the following recommendations for CMS's consideration regarding the Rural Health Transformation Fund.

We are pleased that CMS is prioritizing behavioral health (BH) within the program requirements and expectations in the Rural Health Transformation Fund Notice of Funding Opportunity (NOFO). Rural communities experience disproportionately high rates of suicide[1], substance use disorders (SUD) and untreated mental health (MH) conditions yet face persistent workforce challenges limiting access to BH care services, including crisis care. Focusing on BH will help ensure rural residents have equitable access to high-quality, sustainable care.

CMS should ensure that states develop sustainable BH programs rather than short-term or fragmented initiatives. This includes permanent workforce development programs, the bidirectional integration of BH care into rural primary care settings, and building care coordination systems. Ensuring sustainability beyond the initial funding period is essential for long-term impact.

BH conditions, like depression, anxiety, and SUDs, are chronic diseases that require ongoing management rather than one-time treatment. ABHW encourages CMS and states to emphasize the following evidence-based, measurable strategies that will help states build lasting capacity and strengthen MH and SUD prevention, early detection, and ongoing care.

[1] https://psychiatryonline.org/doi/10.1176/appi.ps.201600024

I. Interoperability and Electronic Health Records

State initiatives should include adopting technology, electronic health records (EHRs), and interoperability within BH settings. MH and SUD providers nationwide have lagged behind other sectors in adopting EHRs. These providers were excluded from the financial incentives established to modernize their health IT infrastructure under the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act. Many rural BH providers, such as community mental health centers and SUD treatment programs, continue to operate with limited or outdated health IT systems, hindering coordination with primary care and other providers. CMS should promote state-level strategies and funding models that help BH organizations implement interoperable EHRs and digital tools that integrate seamlessly with broader health systems. Enhancing these capabilities will improve data sharing and care continuity and support better outcomes for rural populations facing behavioral health challenges.

II. Enhance Rural Crisis Services

CMS should support states in dedicating resources to expand rural crisis services. Investments in mobile crisis teams, crisis stabilization facilities, and 24/7 behavioral health call center capacity will help ensure that individuals in crisis receive timely, community-based interventions. These services reduce reliance on emergency departments and law enforcement, often the only options in rural areas.

Investments in crisis services will also help ensure that appropriate care coordination and follow-up services are available for individuals experiencing a behavioral health crisis across all continuum levels, regardless of whether the patient receives initial care through a 988 call, a health plan crisis line, or an emergency department. This follow-up will help eliminate gaps in care and ultimately lead to better BH outcomes.

In addition, expanding Mental Health First Aid (MHFA) training across the entire ecosystem, including first responders, schools, hospitals, primary care physicians (PCP), and other community partners, will strengthen early identification, de-escalation, and referral to appropriate services. Broader MHFA implementation helps ensure that individuals in crisis receive timely, informed, and compassionate responses wherever they first seek help.

<u>Mobile Crisis Teams</u>

CMS should support states in including initiatives related to mobile crisis teams. States should ensure teams are equipped to refer patients to another facility for additional care needs or assist in arranging transportation. The teams should support ongoing, coordinated care by scheduling follow-up appointments with a warm handoff and notification of all clinically relevant providers, such as BH or PCPs.

Patient data must be accessible to established providers and health plans to improve crisis response and care coordination, while maintaining strong privacy protections. Data should be easily and securely shared as patients transition between levels of care,

ensuring that a patient's health plan and established providers have timely visibility into their treatment and needs across crisis, inpatient, and community-based services.

Peer Support Specialists

ABHW fully supports the inclusion of peer support specialists in state initiatives as invaluable members of mobile crisis teams and in responding to BH crises. Peers can be vital in helping people with MH and SUD conditions, especially those individuals in crisis. Having personally experienced these challenges, peers use informed expertise to guide an individual's recovery in conjunction with an integrated care setting. Peer-to-peer support is an effective, safe, and cost-effective intervention. They help promote individual empowerment while decreasing the need for unnecessary hospitalizations.

III. Strengthening Behavioral Health Services in Rural Hospitals and BH Clinics

As the NOFO suggests, rural hospitals serve as the backbone of care in many communities but often lack the resources to provide robust BH services. More than 60% of non-metropolitan (rural) counties lack a psychiatrist, and the shortages are even more severe for child and adolescent psychiatrists, with approximately 70% of U.S. counties having none at all.[2] Many rural hospitals do not have dedicated BH units or sufficient staff trained to provide comprehensive treatment, such as counseling, psychiatric care, or medications for opioid use disorder (OUD).

CMS should encourage states to use funds to support hospitals and MH and SUD clinics to expand their BH capacity through partnerships and contracts with community providers, building up school-based resources, and embedding behavioral health specialists into hospital settings to strengthen outpatient offerings.

Pathways for Rural Hospitals and BH Clinics to Prescribe MOUDs

ABHW supports expanding access to Medications for Assisted Treatment (MAT) as a proven, evidence-based strategy to address OUD. MAT combines U.S. Food and Drug Administration (FDA) approved medications with counseling and behavioral therapies, helping individuals manage withdrawal symptoms, reduce the risk of relapses, and improve long-term recovery outcomes. Yet despite its effectiveness, MAT remains significantly underutilized, particularly in rural communities where provider shortages, stigma, and geographic barriers make it difficult for patients to access care.
Rural hospitals and BH clinics are significantly less likely than urban hospitals to provide addiction consult services or medications for opioid use disorder (MOUD).[3]

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[2] https://bipartisanpolicy.org/report/behavioral-health-rural-integration

[3] Rural-urban disparities in the availability of hospital-based screening, medications for opioid use disorder, and addiction consult services (2023), https://www.aacap.org/AACAP/Policy_Statements/2023/Behavioral_Healthcare_Workforce_Shortage.aspx (2023).

ABHW urges CMS to work closely with states to implement strategies to support rural hospital and clinic adoption of opioid treatment programs.

Initiatives to Grow the BH Workforce

ABHW encourages all states to create loan repayment and scholarship programs targeted at clinicians who commit to working in rural hospitals and BH clinics (psychiatrists, psychiatric nurse practitioners (NPs), psychologists, licensed clinical social workers (LCSWs)). Additionally, states should expand their scope of practice regulations and remove unnecessary state regulatory barriers so NPs, PAs, and pharmacists can deliver and dispense behavioral health care where appropriate.

Incentive Screening Tools

ABHW encourages states to create initiatives that enable rural hospitals and BH Clinics to adopt behavioral health screening tools. Standardized screening enables earlier detection of MH and SUD conditions, which research shows improves timely treatment and health outcomes.[4] These tools are especially critical for helping non-specialist providers in rural hospitals identify and refer patients appropriately.

IV. Limited BH Workforce Capacity & Cross-State Licensure

Telehealth

For many rural populations, receiving behavioral health care can mean long waits or traveling hours for a single appointment. Telehealth can eliminate these transportation barriers and make specialty care more accessible and sustainable. Access to telehealth services is challenging for rural populations, as data shows that about one in five U.S. households is not connected to the internet at home. A lack of broadband internet is another problem that magnifies obstacles to telehealth access. States should support broadband expansion and digital literacy initiatives to improve equitable access to telehealth in rural areas.

Expanding Licensure Compacts

We were pleased that CMS's NOFO encourages state adoption of licensure compacts and reciprocity agreements, allowing behavioral health providers to serve patients across state lines. Removing these barriers will expand the workforce available to rural areas and significantly improve access to timely care.

The NOFO listed Nurse Licensure Compact (NLC), the Interstate Medical Licensure Compact (IMLC), the Physician Assistant Compact (PAC), the Emergency Medical Services Compact (REPLICA), and the Psychology Interjurisdictional Compact (PSYPACT). We also encourage CMS to add more practitioners to these criteria,

[4] Introducing Mental Health Screening to Primary Care Visits (2025).

including the Social Work Licensure Compact, Mental Health Counselors (MHCs), and Marriage and Family Therapists (MFTs).

Thank you for your attention to these recommendations for the Rural Health Transformation Fund. ABHW is committed to working with CMS, states, and other partners to improve access to behavioral health treatment for all Americans.

Sincerely,

Debbie Witchey, MHA
President and CEO