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

January 26, 2026

Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
United States Department of Health and Human Services
Attention: CMS-9898-NC
P.O. Box 8016, Baltimore, MD 21244-8016

Re: Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program CMS-4212-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) Medicare Program; Contract Year 2027 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program and Medicare Cost Plan Program (NPRM or Proposed Rule).

ABHW is the national voice for payers managing behavioral health insurance benefits. ABHW 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.

I. Star Ratings – Adding Depression Screening and Follow Up Measure

CMS is proposing to add Depression Screening and Follow-Up (DSF) as the first behavioral health measure in the Medicare Advantage (Part C) Star Ratings. This measure would track the percentage of members who are screened for depression using a standardized tool and, if they screen positive, receive follow-up care within 30 days. The goal is to strengthen the Star Ratings program by focusing on meaningful clinical outcomes.

ABHW supports the inclusion of more behavioral health measures, especially those focused on outcomes in the Star Ratings. Depression screening and appropriate follow-up are foundational elements of high-quality, integrated care and can help promote earlier identification of unmet behavioral health needs, reduce the risk of symptom escalation, and support better overall health outcomes for MA beneficiaries. Incorporating DSF into Star Ratings also helps elevate behavioral health on par with physical health conditions, reinforcing its role as a core component of whole-person care. Depression is common and underdiagnosed among Medicare beneficiaries; integrating both screening and follow-up addresses an important behavioral health need and aligns with holistic care models.

We recommend CMS align with the National Committee for Quality Assurance (NCQA) by reporting depression screening and follow-up as two separate measures, rather than averaging the two rates together as one measure. Averaging is not meaningful since the follow-up group is a subset of those screened, which blends distinct populations and undermines accurate assessment. We support including both measures in the Star Ratings and oppose any deviations from NCQA specifications. Reporting each component separately maintains the integrity of measurement and supports performance improvement. The current approach to average the rates may discourage use of the depression screening tool, as plans that screen less can more easily achieve high follow-up rates.

Additionally, all patients diagnosed with Major Neurocognitive Disorder (Dementia) should be excluded from depression screening, as the Patient Health Questionnaire (PHQ-9) is an invalid tool for use in this population.

Since this measure relies on Electronic Clinical Data Systems (ECDS) reporting and Logical Observation Identifiers Names and Codes (LOINC) codes, it may impose administrative and operational burdens on behavioral health providers, particularly small practices and community-based organizations that were not included in prior Electronic Health Record (EHR) incentive programs and continue to face technical barriers to electronic data exchange. CMS should work closely with providers to address these challenges and adopt strategies that incentivize uptake of the necessary codes and reporting infrastructure for the related DSF measure.

Lastly, we are concerned about the practical challenges of collecting and reporting the needed data due to federal and state patient privacy protections that can restrict information sharing. For example, 42 CFR Part 2 (Part 2) is the federal law that imposes strict confidentiality protections on SUD treatment records and generally prohibits disclosure without patient consent. Additionally, some states have additional protections for mental health records that go beyond HIPAA and Part 2, for instance, the California Confidentiality of Medical Information Act (CMIA) places stricter limits on sharing mental health records without patient authorization. These laws can make it difficult for health plans to obtain depression screening results from providers and to document timely follow-up care. We recommend CMS conduct an impact analysis of how federal, state, and territorial privacy laws may affect data availability and reporting for the DSF measure, including patient consent requirements and limitations on sharing behavioral health information to ensure the measure can be feasibly implemented and accurately reported**.**

II. Well-Being & Nutrition

CMS is seeking input on ways to improve overall well-being for MA enrollees, including emotional health, social connection, purpose, and nutrition.

ABHW recommends that CMS advance a value-based framework that promotes whole-person well-being for MA enrollees, including behavioral health. A central element of this framework should be the routine use of standardized screening and prevention-focused quality and cost measures that support early identification and timely follow-up for mental health and substance use disorder (MH/SUD) conditions. Embedding screening and prevention into Medicare Advantage value-based payment models can strengthen care coordination across primary care, behavioral health, and community-based supports that address social drivers of health. Earlier intervention can improve outcomes tied to overall well-being and reduce avoidable utilization associated with untreated behavioral health conditions, while ensuring that MH/SUD care is fully integrated into broader chronic disease management strategies.

III. Outlier Prescriber Criteria

CMS is proposing a system to repeatedly flag providers who consistently prescribe abnormally large amounts of opioids compared to their peers. We support CMS's efforts to strengthen program integrity and address fraud, waste, and abuse related to opioid prescribing, particularly in light of the ongoing opioid overdose crisis. Analytic tools that identify prescribing patterns that are significantly outside clinical norms are an important component of protecting beneficiaries and ensuring appropriate use of controlled substances.

At the same time, it is critical that any provider-flagging methodology incorporate sufficient clinical context and flexibility. Health plans work closely with providers serving high-acuity and complex patient populations, and prescribing patterns may appropriately vary based on patient need. Transparency into the methodology, regular updates to reflect evolving clinical practice, and safeguards against the use of outdated benchmarks are essential to avoid unintended disruptions to care.

We appreciate CMS's acknowledgement that methodologies should evolve over time and its intent to prevent providers from being penalized based on static or obsolete measures. Ongoing refinement, clear communication with providers and health plans, and an emphasis on education and corrective action prior to enforcement will help ensure this approach effectively addresses inappropriate prescribing while preserving access to medically appropriate pain management and evidence-based treatment.

Thank you for the opportunity to provide feedback on this NPRM. We are committed to engaging with CMS and other partners to find opportunities to improve behavioral health access for all individuals. If you have questions, please contact Kathryn Cohen, Senior Director of Regulatory Affairs, at cohen@abhw.org.

Sincerely,

Debbie Witchey, MHA
President and CEO