ABH
ASSOCIATION FOR BEHAVIORAL HEALTHCARE

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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2449-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on Proposed Rule: Medicaid Program; Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P)

Dear Administrator:

The Association for Behavioral Healthcare (ABH) is a statewide association located in Massachusetts representing eighty-one community-based mental health and addiction treatment provider organizations. ABH's members are the primary providers of publicly funded behavioral healthcare services, serving approximately 81,000 residents daily, 1.5 million residents annually, and employing over 46,500 people. Many of our members deliver behavioral health treatment services in the insurance-based delivery services, such as therapy, medication management, and the full continuum of ASAM substance use treatment services, and our members offer critical access for families and individuals enrolled in Medicaid.

We appreciate the opportunity to comment on CMS's proposed rule governing Medicaid managed care state directed payments (SDPs) and fee-for-service (FFS) targeted payments. We support CMS's goals of fiscal integrity and transparency; however, the elimination of state directed payment and the proposed expansion of Medicare-based upper payment limits to additional provider types and FFS targeted payments would harm community-based behavioral health services and weaken an already fragile safety net. We urge CMS to modify the final rule.

1. Eliminate the Unauthorized Expansion to Behavioral Health Providers and FFS

CMS's proposal to apply Medicare-linked payment caps to all FFS targeted payments and additional managed care provider types exceeds the statutory directive in H.R.1 (OBBBA). Section 71116 of Pub. L. No. 119-21 does not authorize a sweeping Medicare-based rate cap on either state directed or FFS targeted payments to community-based behavioral health services.

Community-based behavioral health services do not present the same concerns CMS identifies for inpatient hospitals, outpatient hospitals, nursing facilities, or academic medical centers, where benchmarking to average commercial rates has produced state directed payment rates well above Medicare. Commercial rates for behavioral health services have historically remained below Medicare nationally and below primary care and medical/specialty rates. Milliman's 2019 report, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement*, found that commercial payment for behavioral health care averaged 97% of Medicare nationally, compared with 120% of Medicare for primary care.[i]

Medicaid-specific data confirm that behavioral health benchmarking to average commercial rates is not the problem. In *Estimating Medicaid Reimbursement For Psychological Services*, Zhu, Huntington,

Mitchell, and Last analyzed publicly available Medicaid FFS schedules for sixteen commonly used behavioral health CPT codes across forty-six states and Washington, D.C. They found that Medicaid paid, on average, 74.0% of Medicare for psychological services; only three states paid above Medicare, four paid less than half of Medicare, and twenty-three paid between 50% and 75% of Medicare. [ii] Medicaid behavioral health rates remain significantly below Medicare in most states. Limiting state-directed increases would discourage states from targeting much needed investments in access to treatment for mental health and substance use.

Massachusetts' directed minimum fee schedule was designed to reduce wide rate disparities that emerged after managed care expansion, impacting provider stability and exacerbating workforce erosion. States like Massachusetts are using SDPs and targeted FFS adjustments to invest in community-based behavioral health because reimbursement has fallen behind the cost of care, particularly as more Medicaid behavioral health volume has shifted to managed care. **Including behavioral health in the final rule would remove an important state tool for correcting market failures that threaten Medicaid network participation and patient access.**

2. At Minimum Do Not Apply Medicare's Non-Physician Practitioner Discount to Medicaid Behavioral Health Rates

If CMS retains behavioral health within the rule's scope – which we strongly discourage due to the reasons above- we urge CMS not to apply Medicare's 75% non-physician practitioner (NPP) discount to either the proposed SDP limit or the proposed FFS targeted practitioner payment limit. CMS recently used Section 1115 Special Terms and Conditions to require seven states to maintain or progressively increase Medicaid behavioral health rates to *at least* 80% of the Medicare Physician Fee Schedule. This provision was designed to hold back federal matching funds from states with underfinanced behavioral health systems. Applying a rate *ceiling* to behavioral health at the lower NPP percentage contradicts this well-reasoned policy, ignores local workforce economics and undervalues the master's-level clinicians who provide most direct behavioral health care.

Massachusetts data illustrate the impact. MassHealth directs managed care plans to pay a minimum fee schedule for mental health centers providing outpatient behavioral health CPT codes. Managed care rates for master's-level clinicians in those centers are approximately 68% to 84% of Medicare and trail more recently updated FFS rates, which are approximately 75% to 92% of Medicare.

- **Immediate rate reductions:** Applying the 75% NPP rule to master's-level clinicians would reduce managed care rates for high-volume psychotherapy codes 90834 and 90837 by up to 10% for providers outside Boston. Applying the same limit to current FFS state plan rates would reduce rates by 8% for Boston-area providers and 17% for providers elsewhere, including in all rural areas of the state.

Master's Level Clinicians								
CPT Code & Modifier	**Appendix L Rate - *MCO Directed Minimum Payment***	**101 CMR 306.00 Rate - *State Plan FFS Rates***	**100% Boston Medicare Rate**	**100% "Rest of MA" Medicare Rate**	**App. L % of Medicare Boston**	**Appendix L % of Medicare "Rest of MA"**	**FFS % of Medicare Boston**	**FFS % of Medicare "Rest of MA"**
90791	$130.48	$143.53	$192.10	$174.34	**68%**	**75%**	**75%**	**82%**
90832	$57.80	$63.58	$84.20	$76.42	**69%**	**76%**	**76%**	**83%**
90834	$95.60	$105.16	$126.35	$114.64	**76%**	**83%**	**83%**	**92%**
90837	$141.20	$155.32	$186.20	$169.05	**76%**	**84%**	**83%**	**92%**

- **Erosion of progress:** The limit would leave managed care rates for master's-level clinicians below current levels and below more recently updated state plan rates. Because Massachusetts state plan increases often are not reflected in capitation until the following rate year, the proposed rule could

freeze managed care rates and erase years of incremental investment, including increases that have only just begun to approach 100% of Medicare to cover the higher costs of full-service mental health centers.

Forcing rate rollbacks during a nationwide mental health workforce shortage would conflict with CMS's stated goal of expanding behavioral health access. At minimum, CMS should preserve state flexibility by eliminating any requirement to apply Medicare's 75% NPP discount to the upper payment limit. Allowing states to set rates for behavioral health NPP services up to 100% of the Medicare Physician Fee Schedule would create room for meaningful investment in historically underfunded services and help redirect federal matching funds toward preventive and recovery-oriented community-based care.

3. Allow Exclusions for Integrated Behavioral Health Access Models

CMS should create an explicit exclusion from the payment-limit methodology for advanced behavioral health access and integrated delivery models. States that do not participate in the Section 223 federal Certified Community Behavioral Health Clinic (CCBHC) Demonstration should be able to fund substantially similar state-defined models, such as Massachusetts' Community Behavioral Health Centers (CBHCs) and Behavioral Health Urgent Care centers (BHUCs), which operate under state plan authority with managed care directed payment. Massachusetts has committed substantial state dollars to develop a network of multi-service, rapid access CBHCs and BHUCs without relying on the enhanced federal matching funds available through the Section 223 CCBHC Demonstration.

Massachusetts' CBHC and BHUCs must meet detailed performance specifications that mirror requirements for CCBHCs – and on several dimensions even exceed CCBHC criteria. Like CCBHCs, the MA CBHC and BHUC service models combine open access, wrap-around support, and clinical treatment in ways that discrete CPT-code reimbursement does not capture. Meeting the requirements involves staffing and infrastructure costs that are not experienced by providers delivering traditional Medicare-equivalent outpatient services. Because these models have no analog in traditional FFS Medicare or standard managed care CPT fee schedules, CMS should clarify that states that are not participating in the federal CCBHC Demonstration may also establish payment methodologies for comprehensive integrated care models, including but not limited to cost-based, prospective methodologies. Excluding integrated behavioral health care access models from per-service Medicare rate caps would afford more states the flexibility needed to finance – and accelerate - behavioral health system innovations.

4. Continue to Use Federal Policy to Set Minimum Rate Targets – rather than Rate Caps – to Ensure State Investment in Behavioral Health Rate Adequacy

CMS recently used Section 1115 Special Terms and Conditions to require at least seven states to progressively increase or maintain behavioral health rates at a minimum of 80% of the Medicare Physician Fee Schedule.[1] These provisions ensure states cannot leverage incremental federal funding to cover new services while simultaneously underfunding primary care and behavioral safety nets.

The core regulatory logic stands: federal matching dollars should not be used for incremental Medicaid investments while coverage of core mental health and substance use treatment remains underfinanced. This policy approach is consistent with the current Administrations' executive orders and initiatives aimed at advancing access to behavioral health treatment and support for long-term recovery and self-sufficiency through the Great American Recovery Initiative and Office of National Drug Control Policy (ONDCP) Drug Policy Priorities and National Drug Control Strategy to combat chronic disease through Make America Healthy Again (MAHA).

[1] This rule was included under the "Provider Rate Increase Requirements" section of the Special Terms and Conditions (STCs) for states approved to implement Health-Related Social Needs (HRSN) frameworks or Designated State Health Programs (DSHP) Section 1115 waivers.

In setting 1115 Waiver terms CMS identified the 80% Medicare threshold as a minimum baseline target for rate adequacy. As evidenced in the studies cited above, the problem for behavioral health is not that rates are too high compared to Medicare, it is that they are too low. State efforts to establish competitive market rates – including Massachusetts' - suggest the 80% minimum threshold is insufficient in areas where workforce shortages are eroding access and putting upward pressure on provider costs. Thus, establishing a maximum rate benchmark under the SDP rule that is below 80% for much of the behavioral health workforce providing care erodes the ability to drive progress towards access. Setting minimum targets for behavioral health rate solvency remains a more powerful tool for advancing behavioral health access priorities.

Thank you for your consideration.

Sincerely,

Lydia D. Conley
President/CEO

[i] Steve P. Melek, Stoddard Davenport, and T.J. Gray, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement*, Milliman (Nov. 2019).
[ii] Jane M. Zhu, Aine Huntington, Emily Mitchell, and Briana Last, *Estimating Medicaid Reimbursement For Psychological Services*, *Health Affairs* 44, no. 12 (2025): 1530–1536, doi:10.1377/hlthaff.2025.00563.