Maryland Behavioral Health Coalition

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July 20, 2026

The Honorable Robert Kennedy, Jr.
Secretary Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Dr. Mehmet Oz
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P)

Dear Secretary Kennedy and Administrator Oz:

Thank you for the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule on Medicaid Managed Care State Directed Payments and Medicaid Fee-for-Service Targeted Medicaid Practitioner Payments (CMS-2449-P). The undersigned members of the Maryland Behavioral Health Coalition, a group of state and local organizations advocating for policies to increase access to quality mental health and substance use care, respectfully urge CMS not to finalize these rules as proposed. **Specifically, we urge CMS not to finalize the proposed changes to Medicaid fee-for-service (FFS) targeted Medicaid practitioner payments.** This rule would have serious negative consequences for Maryland's community mental health and substance use providers, as these services are reimbursed on a FFS basis and are not part of Maryland's managed care system.

The need for quality mental health and substance use care has never been greater. More than 30% of Marylanders in need of counseling or therapy do not receive it, a rate that exceeds the national average.[1] Maryland's percentage of serious suicidal ideation among youth aged 12-17 is 5th highest in the nation.[2] Maryland's 988 helpline received nearly 20,000 calls in March 2026, an increase of nearly 20% over the same month last year. And while, thankfully, overdose deaths are declining, there were still nearly 1,300 Marylanders who lost their lives to overdose over the past year.[3]

[1] https://www.kff.org/interactive/mental-health-and-substance-use-state-fact-sheets/maryland
[2] Reinert, M, Nguyen, T & Fritze, D. (October 2025). "The State of Mental Health in America 2025." Mental Health America, Alexandria VA. https://mhanational.org/the-state-of-mental-health-in-america/
[3] https://health.maryland.gov/dataoffice/Pages/mdh-dashboards.aspx?ref=opioiddatalab.ghost.io

Access to quality behavioral health care is fundamental to the health and wellbeing of Maryland communities, but reimbursement for the professionals and paraprofessionals delivering critical community-based mental health and substance use care has not kept up with the increased costs of doing business. Average salaries for Maryland counselors in the behavioral health field have increased 34% since 2020, and psychiatrist salaries have increased 32%,[4] but Medicaid rates have not kept pace. As a result, Maryland is experiencing an acute public behavioral health workforce shortage, the extent of which was documented in an October 2024 report by the Maryland Health Care Commission.[5] According to MHCC, low pay is the number one cause of this workforce crisis; a claim that is supported by data showing that 75% of community behavioral health counselors and social workers do not make a living wage based on the Maryland cost of living when compared to social workers and counselors in comparable roles in schools, hospitals, or private practice.[6]

The proposed rule would exacerbate Maryland's behavioral health workforce challenges by capping reimbursement for Medicaid FFS providers at FFS Medicare payment rates.

According to research by your department, reimbursement rates in Medicare are not sufficient to enlist enough providers so that mental health and substance use care is available when and where needed. In 2024, the U.S. Department of Health & Human Services Office of Inspector General (OIG) released a report highlighting how the lack of behavioral health providers in Medicare and Medicaid impedes enrollees' access to care.[7] Key findings include:

- Few behavioral health providers actively serve Medicare enrollees. On average, there are 2.9 active behavioral health providers per 1,000 Medicare FFS enrollees.
- Active providers in Medicare and Medicaid represented only about one-third of the total behavioral health provider workforce. Notably though, Medicaid was higher than Medicare FFS: 38% of behavioral health providers actively participated in Medicaid, compared to only 29% in Medicare FFS. The report pointed to low payment rates as one of the reasons for this limited participation.
- Eight percent of Medicaid enrollees received treatment from a behavioral health provider, twice the rate of enrollees receiving behavioral health care in Medicare FFS (4%). Importantly, Medicaid enrollees most often saw counselors and social workers, who are reimbursed at a lower rate in Medicare than other non-physician practitioners, as discussed further below.

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[4] U.S. Bureau of Labor Statics, Occupational Employment and Wage Statistics. Maryland data for psychiatrists (29-1223) and behavioral health counselors (21-1018) from 2020 to 2024.
[5] Maryland Health Care Commission. Investing in Maryland's Behavioral Health Talent. October 2024.
[6] Massachusetts Institute for Technology. Living Wage Calculator - Living Wage Calculation for Maryland. Accessed November 14, 2025.
[7] U.S. Department of Health & Human Services, Office of Inspector General, "A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care," U.S. Department of Health & Human Services, OEI-02-22-00050 (Mar. 2024), https://oig.hhs.gov/documents/evaluation/9844/OEI-02-22-00050.pdf.

Additional research suggests that Medicare is not consistent with quality of care for substance use disorders. A study published last year in Health Affairs examined nationally recognized quality measures for opioid use disorder (OUD) treatment in Medicare and Medicaid, and found that Medicaid surpassed Medicare on all measures examining the quality of care for OUD:[8]

- Only 36% of Medicare FFS beneficiaries with OUD initiated treatment (started OUD treatment within 14 days of a new OUD diagnosis), compared to 55% of Medicaid enrollees.
- Only 15% of Medicare FFS beneficiaries with OUD engaged in treatment (received two or more additional OUD services or medications within 34 days of their initiation visit), compared to 30% of Medicaid enrollees.
- Only 21% of Medicare FFS beneficiaries with OUD were treated with medications for opioid use disorder (MOUD), the gold standard of treatment for this condition, compared to 57% of Medicaid enrollees. Notably, more recent data suggests that the rate of access to MOUD has continued to increase in Medicaid such that it is now nearly 70%,[9] whereas the Medicare rate has stayed relatively constant at around one in five enrollees.[10]

The Social Security Act requires a Medicaid state plan "to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30). The studies referenced above demonstrate that Medicare FFS payment rates do not meet these standards.

This is not surprising. Medicare is not subject to the Mental Health Parity and Addiction Equity Act (MHPAEA), the anti-discrimination law that requires reimbursement rates – among other non-quantitative treatment limitations – to be designed and applied in a way that is comparable for mental health and substance use disorder providers as for medical and surgical providers. Moreover, payments under the Medicare Physician Fee Schedule are generally higher for clinical procedures such as surgeries and diagnostic tests,[11] and lower for non-procedural services that mental health and substance use disorder providers deliver like counseling and psychotherapy. By contrast, states currently have the flexibility in Medicaid to set rates that are sufficient to enlist counselors and other mental health and substance use disorder providers, and they are required to

[8] Tami L. Mark et al., "The Quality of Opioid Use Disorder Treatment in Medicare is Low and Lags Behind Medicaid," Health Affairs (Sept. 2, 2025), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2025.00207.
[9] Thanh T. Lu et al., "Cascade of Care for Opioid Use Disorder Among Medicaid Beneficiaries," JAMA Network (Apr. 22, 2026), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2848015.
[10] U.S. Department of Health & Human Services, Office of Inspector General, "Fewer than One in Five Medicare Enrollees Received Medication to Treat Their Opioid Use Disorder," U.S. Department of Health & Human Services, OEI-02-24-00430 (Apr. 2025), https://oig.hhs.gov/documents/evaluation/10253/OEI-02-24-00430.pdf.
[11] Alex Cottrill, Juliette Cubanski, & Tricia Neuman, "What to Know About How Medicare Pays Physicians," KFF (Oct. 7, 2025), https://www.kff.org/medicare/what-to-know-about-how-medicare-pays-physicians/.

comply with MHPAEA for managed care plans (and FFS when some benefits are delivered via managed care), alternative benefit plans, and the Children's Health Insurance Program (CHIP).

Even more alarmingly, CMS has proposed that states would have to further limit targeted Medicaid payments for providers who are not reimbursed at the full Medicare FFS rate. The proposed rule highlights how certain non-physician practitioners – nurse practitioners, physician assistants, and clinical nurse specialists – are reimbursed at 85% of the physician rate in Medicare. The proposed rule does not even acknowledge that non-physician behavioral health practitioners – clinical social workers, mental health and addiction counselors, and marriage and family therapists – are only reimbursed at 75% of the physician rate in Medicare. This amount would be inconsistent with "quality of care," and certainly insufficient "to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Quality, accessible mental health and substance use care is essential to the wellbeing of our children, families, and communities. **We urge you to reconsider the proposed changes to Medicaid FFS targeted Medicaid practitioner payments.**

Thank you for considering these comments. Please contact Dan Martin with any questions at dmartin@mhamd.org.

Sincerely,
Affiliated Santé Group
Behavioral Health System Baltimore (BHSB)
B'More Clubhouse
Carroll County Youth Service Bureau (CCYSB)
Catholic Charities
Chesapeake Voyagers
Community Behavioral Health Association of Maryland (CBH)
Cornerstone Montgomery
Gaudenzia
Grassroots Crisis Intervention
Greater Washington Society for Clinical Social Work (GWSCSW)
Horizon Foundation of Howard County
Hudson Behavioral Health
IBR REACH
James' Place
Key Point Health Services
Legal Action Center (LAC)
Licensed Clinical Professional Counselors of Maryland (LCPCM)

Maryland Addiction Directors Council (MADC)
Maryland Alliance for Sensible Drug Policy (MASDP)
Maryland Association for the Treatment of Opioid Disorders (MATOD)
Maryland Association of Youth Service Bureaus (MAYSB)
Maryland Coalition of Families (MCF)
Maryland Counseling Association (MCA)
Maryland-DC Society of Addiction Medicine (MDDCSAM)
Maryland Psychiatric Society (MPS)
Mental Health Association of Frederick County
Mental Health Association of Maryland (MHAMD)
Mid Shore Behavioral Health (MSBH)
Montgomery County Federation of Families for Children's Mental Health
National Alliance on Mental Illness, Maryland (NAMI Maryland)
National Council on Alcoholism and Drug Dependence – Maryland (NCADD-Maryland)
On Our Own of Maryland (OOOMD)
Powell Recovery Center
Pro Bono Counseling Project
Pyramid Healthcare
Sheppard Pratt
Wells House

cc: Maryland Congressional Delegation