REDC
Highest Standards of Care

September 13, 2021

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Humans Services
Attention: CMS-9906-P, P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via regulations.gov

RE: RIN 0938—AU42; CMS-1751-P
Updating to Medicare Programs; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.

Dear Administrator Brooks-LaSure:

On behalf of the REDC Consortium please accept the written comments below in response to CMS's proposed rule "Medicare Program CY 2022 Payment Policies Under the Physician Fee Schedule", or PFS. The REDC Consortium is a national trade association of eating disorder treatment centers, representing approximately 85 percent of the higher levels of eating disorder care centers in the United States including inpatient, residential, partial hospitalization, day program, and intensive outpatient treatment. Our members agree to treatment and operational standards including accreditation by the independent accrediting bodies of the Joint Commission and/or Commission on Accreditation of Rehabilitation Facilities (CARF), conduct collaborative research, and work together to address treatment access issues facing individuals with eating disorders and their families. Most recently, the REDC Consortium launched the Standards of Excellence Project (STEP), which represents the strongest, clearest, declaration of the patient-centered values, beliefs, and principals that guide our members work every day. Our ultimate mission is to collaboratively address issues impacting treatment programs to increase access to treatment for individuals struggling with eating disorders.

REDC members are in the business of treating people affected by the serious mental illness of eating disorders and co-occurring conditions associated with the disorder, including substance use disorder. Eating disorders are complex, biologically-based serious mental illnesses that have the second highest mortality rate of any psychiatric illness—with one person losing their life every 52 minutes as a direct result of an eating disorder.[1] Approximately 28.8 million Americans experience a clinically significant eating disorder during their lifetime[2], affecting individuals of all ages, races, genders, ethnicities, socioeconomic backgrounds, body sizes, and sexual orientations.[3] Under the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: DSM-5, eating disorders include the specific disorders of anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake

[1] Deloitte Access Economics. The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders. June 2020. Available at: https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/
[2] Ibid.
[3] Le Grange, D., Swanson, S. A., Crow, S. J., & Merikangas, K. R. (2012). Eating disorder not otherwise specified presentation in the US population. *International Journal of Eating Disorders*, 45(5), 711-718.

disorder, and other specified feeding or eating disorders.[4] These disorders are unique in that they co-occur and can lead to several mental health and medical complications. For example, 25 percent of people experiencing an eating disorder have a co-occurring substance use disorder.[5] Additionally, eating disorders are associated with a range of medical complications including cardiac disability, starvation, hepatitis, refeeding syndrome, cognitive dysfunction, kidney failure, esophageal cancer, osteoporosis, fractures (hip, back, etc.), hypoglycemic seizures, amenorrhea, infertility, high and low blood pressure, Type II diabetes mellitus, edema (swelling), high cholesterol levels, gall bladder disease, decalcification of teeth, severe dehydration, chronically inflamed sore throat, and inflammation and possible rupture of the esophagus.[6, 7]

When families across the nation do not have affordable and comprehensive insurance coverage that includes mental health and substance use disorder (MHSUD) treatment at all levels of care, they are not able to be admitted into specialized facilities like ours for lifesaving treatment without finding the out-of-pocket means to cover their care. Studies show that when a person with a severe eating disorder like anorexia does not receive comprehensive treatment, 41 percent of patients will relapse and are two times more likely to end up in the emergency room than someone without an eating disorder.[8] The U.S. economic impact of these eating disorder readmissions amount to $29.3 million in emergency room visits annually and $209.7 million for inpatient hospitalizations annually.[9] Barriers to comprehensive treatment cost the U.S. $64.7 billion each year with individuals and families shouldering $23.5 billion, government shouldering $17.7 billion, and employers shouldering $16.3 billion respectively.[10]

In turn, we will only be addressing parts of Section D of the proposed rule as continued telehealth access for our population is most pressing. Overall, we support many of the telehealth provisions within PFS Rule to expand telehealth opportunities after the COVID-19 PHE ends, provide greater access to telehealth, the use of audio-only communications, and increased data collection to minimize the gap in achieving health equity. We look forward to working with you in the future to continue to improve access to comprehensive and affordable care for all, and welcome follow-up conversations to discuss further.

Sincerely,

Dr. Jillian Lampert, PhD, RD, LD, MPH, FAE
President, REDC Consortium

[4] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5.* Washington, D.C: American Psychiatric Association.
[5] Bahji, A., Mazhar, M. N., Hawken, E., Hudson, C. C., Nadkarni, P., & MacNeil, B. A. (2019). Prevalence of substance use disorder comorbidity among individuals with eating disorders: a systematic review and meta-analysis. Psychiatry Research, 273, 58-66.
[6] Westmoreland, P., Krantz, M. J., & Mehler, P. S. (2016). Medical complications of anorexia nervosa and bulimia. *Am J Med*, 129(1), 30–37.
[7] Thornton, L. M., Watson, H. J., Jangmo, A., Welch, E., Wiklund, C., von Hausswolff-Juhlin, Y., . . . Bulik, C. M. (2017). Binge-eating disorder in the Swedish national registers: somatic comorbidity. *Int J Eat Disord*, 50(1), 58-65.
[8] Tackling Relapse Among Anorexia Nervosa Patients. (2013). *Eating Disorders Review*, 24, 9-11.; Yafu Zhao, M., & Encinosa, W., Ph.D. (2011, September). An Update on Hospitalizations for Eating Disorders, 1999 to 2009. Retrieved from http://www.hcup-us.ahrq.gov/reports/statbriefs/sb120.jsp
[9] Deloitte Access Economics. The Social and Economic Cost of Eating Disorders in the United States of America: A Report for the Strategic Training Initiative for the Prevention of Eating Disorders and the Academy for Eating Disorders. June 2020. Available at: https://www.hsph.harvard.edu/striped/report-economic-costs-of-eating-disorders/.
[10] Ibid.

I. Section II Subsection D: Implementation of Provisions of the Consolidated Appropriations Act, 2021 (CAA)

a. Removal of Geographic & Site Restrictions

The passage of the Consolidated Appropriations Act, 2021 (CAA) (P.L. 116-260) was a strong step forward to enhance telehealth access. **Specifically, the REDC Consortium is supportive of the amendment to Section 123 of the CAA to remove geographic restrictions for all Medicare beneficiaries. This allows the patient's home to be a permissible originating site for telehealth services for the purposes of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished on or after the end of the Public Health Emergency (PHE) for COVID-19.** The pandemic has highlighted the disparities in our health care system and the need to expand access to comprehensive mental health care, especially in underserved populations. Prior to the pandemic, 75 percent of U.S. counties experienced severe shortages of mental health providers.[11] Between the onset of the PHE and the summer of 2020, 60 percent of Medicare beneficiaries utilized telehealth services to see a psychiatrist or psychologist.[12] Last, according to claims data from FAIR Health, mental health conditions accounted for almost 60 percent of the top 5 diagnoses in April 2021, which is an approximate 25 percent increase from April 2020.[13, 14] This rapid increase in utilization demonstrates telehealth flexibilities are fulfilling a critical need for Americans mental health across the country.

b. Six Month Interval In-Person Requirement

Our membership can attest to the rise in mental health utilization as we work on the frontlines to provide lifesaving care. Our treatment sites pivoted quickly to telehealth for our partial hospitalization program (PHP) and intensive outpatient program (IOP) levels of care. This allowed for our patients in residential care or who required PHP in-person treatment to safely continue receiving care. At this time, we estimate about 75 percent of our members are delivering care via telehealth in addition to providing in-person services. Given the complexity of eating disorders, comprehensive care for this psychiatric illness requires a multidisciplinary team of providers that typically includes a medical provider, psychiatrist, psychologist, and a nutritionist. This specialty care is not always readily available and because of this, **the REDC Consortium opposes the six month, in-person requirement with the physician or practitioner to the initial telehealth service, and at least once every six months thereafter.** This provision is discriminatory against individuals with mental health conditions as no in-person requirement is required for individuals seeking treatment for substance use disorder. This arbitrary requirement puts burdensome travel and safety concerns on the beneficiary, families, and loved ones.

[11] Macher, D., Seidman, J., Gooding, M., & Diamond, C. (2020, May 11). COVID-19 is Stressing a Fractured Mental Healthcare System in the US. https://avalere.com/insights/covid-19-is-stressing-a-fractured-mental-healthcare-system-in-the-us.
[12] Koma, Wyatt; Cubanski, Juliete & Neuman, Tricia. (May 19, 2021). Medicare and Telehealth: Coverage and Use During the COVID-19 Pandemic and Options for the Future. Kaiser Family Foundation. Retrieved from https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-optionsfor-the-future/.
[13] FAIR Health. Monthly Telehealth Regional Tracker, Mar. vs. Apr. 2021, United States Month-to-Month Comparison. Retrieved from https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/apr-2021-national-telehealth.pdf
[14] FAIR Health. Monthly Telehealth Regional Tracker, Apr. 2020, United States. Retrieved from https://s3.amazonaws.com/media2.fairhealth.org/infographic/telehealth/apr-2020-national-telehealth.pdf

Although Medicare does not cover residential, PHP (outside of a hospital), IOP programming, dietitian services or even an assessment from an eating disorder specialist, we understand the commercial insurance market relies heavily on Medicare benefit designs to inform their own coverage policies. Although the Mental Health Parity and Addiction Equity Act (MHPAEA) does not apply to Medicare, devising policies that blatantly flout a federal law does a disservice for all Americans seeking treatment for mental health conditions and sets the tone for the continuation of commercial payers to remain incompliant.

The in-person requirement has been sold as a way to mitigate fraud; however, fraud for mental health conditions provided via telehealth have yet to surface. Congress and federal agencies appear to be legislating and regulating for a problem that does not exist. Additionally, studies continue to be conducted that illustrate the positive clinical outcomes of eating disorders treatment delivered via telehealth. A July 2021 study compared eating disorder care in a telehealth (virtual) IOP setting vs. IOP in-person setting and found no differences in patient outcomes.[15] The findings included a significant decrease in eating disorders symptoms, depression, and perfectionism and a significant increase in body mass index/weight restoration.[16] Another study examined outcomes of providing telehealth (virtual) IOP services and reported significant and clinically meaningful improvements in all outcomes measured including self-reported eating disorders symptoms, depression and self-esteem, and overall quality of life.[17] Expanding access to eating disorders care through telehealth continues to fill a great need for individuals without transportation, individuals in communities where there are no local treatment options for specialized care, individuals residing in areas with inclement weather, and for individuals with co-occurring conditions that make it feasible to participate in treatment from home whereas their condition would normally result in a no-show appointment.

c. Payment for Medicare Telehealth Services Furnished Using Audio-Only Communication Technology

The REDC Consortium supports the proposed amendment to regulation § 410.789(a)(3) to define and expand "interactive telecommunications system" to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health patients provided to established patients when the originating site is the patient's home. Audio-only visits have been a lifeline for patients during the PHE, especially to seniors, rural individuals, and communities of color who have been hit hardest by COVID-19. For example, a study from the Centers for Disease Control and Prevention (CDC) utilized data from 14 participating states to show COVID-19 mortality among American Indian and Alaska Native persons was 1.8 times that among-non-Hispanic Whites.[18] These same communities have limited to no internet services, stressing the need for continued use of audio-only communications. Requiring both video and audio components would also exacerbate

[15] Levinson, C., Spoor, S., Keshishian, A., & Pruitt, A. Pilot outcomes from a multidisciplinary telehealth versus in-person intensive outpatient program for eating disorders during versus before the Covid-19 pandemic. *Int J Eat Disord.* 2021 July 10. https://doi.org/10.1002/eat.23579.
[16] Ibid.
[17] Blalock, D., LeGrange, D., Johnson, C., Duffy, A., Manwaring, J., Tallent, C., Schneller, K., Solomon, A., Mehler, P., McClanahan, S., & Rienecke, R. Pilot assessment of a virtual intensive outpatient program for adults with eating disorders. Eur *Eat Disorders Rev.* 2020; 28:789-795. https://doi.org/10.1002/erv.2785
[18] Arrazola J, Masiello MM, Joshi S, et al. COVID-19 Mortality Among American Indian and Alaska Native Persons — 14 States, January–June 2020. MMWR Morb Mortal Wkly Rep 2020;69:1853–1856. DOI: http://dx.doi.org/10.15585/mmwr.mm6949a3external icon.

health care disparities for Blacks and older individuals. A study from the University of Alabama-Birmingham revealed that Blacks were 28 percent less likely to use video compared with Whites, and patients 60 or older were up to 49 percent less likely to use video than younger individuals.[19] These disparities showcase the importance of audio-only telehealth options.

Further, research has shown that over 21 million Americans live in "digital deserts."[20] While lack of broadband access is viewed as a problem for rural communities, it is also a barrier to care for urban areas. This is due to poor broadband infrastructure, affordability, or incapability to use devices that permit a two-way, audio/video interaction for their health care visits. As the CMS proposed rule mentions, there has been a steady utilization trend for audio-only communication from April 2020 to present and it is highly likely to be utilized after the PHE ends. Audio-only telehealth has opened opportunities to vital behavioral health services; this care must remain accessible post-pandemic.

In addition to allowing the audio-only communications for routine appointments, the REDC supports allowing high-level services, such as crisis psychotherapy to have use of audio-only telehealth. A mental health crisis can happen anywhere and at any time and requires immediate attention. There should be nothing that delays or discourages immediate contact with a provider. Audio-only telephones are the easiest telecommunications devices for many beneficiaries to access, as was described above.

Last, we oppose requiring additional documentation for coverage of audio-only services. Providers already have a well-documented medical record that provides adequate information needed to justify medical necessity for this service. Under the proposed rule, providers will have to self-certify that they have two-way audio-visual telecommunications devices, but the patient requires or choses to receive the audio-only service. No other documentation should be required beyond self-certification.

II. Section III, Subsection B: Telehealth Availability for FQHC & RHCs

The REDC Consortium supports the PFS provisions to improve and expand the scope of telehealth services, including mental health visits to those living in rural areas and in certain specified types of "originating sites" including physical offices, hospitals, and other medical care settings through the inclusion of Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). As community-based health care providers, FQHCs are essential resources in underserved communities. Their services target health disparities and work to provide high-quality patient care. Rural providers play a significant role in delivering timely, effective, and safe care. Allowing telehealth services to be provided will allow patients to continue to use their services. RHCs and FQHCs can leverage telemedicine technology to connect patients to off-site specialists. Through video, urban hospitals can remotely access, diagnose, and guide treatment to patients at the clinics. Rural hospitals can identify needs of the local community and use this knowledge to partner with urban health systems and regional medical centers to make needed services available. RHCs also allow more personalized care which is invaluable to the treatment of mental health conditions. Studies have shown that rural providers typically outperform counterparts in the "experience of care."[21]

[19] Wallace. Telehealth. Setting it all up. Presented at Cancer Center Survivorship Research Forum. April 2021. Healio.com/news/hematology-oncology/20210415/speaker-use-telehealth-to-resdesign-health-care-with-the-patient-in-mind.
[20] Federal Communications (2020). Broadband Deployment Report. Accessed at https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2020-broadband-deployment-report
[21] Pratt, Mary Ellen. (August 10, 2017). The Importance of Rural Healthcare. https://www.sjph.org/health-education-blog/the-importance-of-rural-healthcare-by-mary-ellen-pratt-faches-ceo/

Many FQHCS did not have telehealth services during the pandemic resulting in a 26 percent decline in patient visits and over 25,000 staff laid off from the start of the pandemic to June 2021.[22] Patients who access care through FQHCs or RHCs face many barriers to care, often causing them to receive no treatment at all. Mental health services are critical to the overall health status of rural and urban residents alike. Without access to these services, conditions such as depression, anxiety, or substance use disorder remain untreated which can potentially lead to worsening conditions or disease progression of the patient. Expanding the scope of telehealth to RHCs and FQHC increases local access and eliminates barriers to care.

III. Section IV, Subsection D: Closing the Health Equity Gaps in CMS Clinician Quality Programs

The REDC supports the PFS proposed rule to increase efforts to collect data from Medicare beneficiaries to help improve health care disparities. We are pleased CMS recognizes and acknowledges the gap in health equity across the nation and is committed to improving data collection to better measure and analyze disparities across programs and policies. CMS currently does not consistently collect self-reported race and ethnicity for the Medicare program, but rather gets the data from the Social Security Administration (SSA). CMS's proposal to collect this data and expand the available race categories will produce more accurate identification and analysis of health disparities based on race and ethnicity. Incorrectly classified race and ethnicity could result in over or under estimation in the quality of care received by certain groups of beneficiaries.

Unfortunately, among Medicare beneficiaries, racial and ethnic minority persons often experience worse health outcomes, including more frequent hospital readmissions and procedural complications. For example, a study analyzing electronic health records from 53 health systems across 21 states found among patients who test positive for COVID-19, Black, Hispanic, and Asian patients were at higher risk for hospitalization and death compared to White patients.[23] Further, Native Hawaiian/Pacific Islander, American Indian/Alaskan Native and Hispanic populations experienced higher COVID-19 case rates compared to Black, White, and Asian populations.[24] In addition to CMS's proposal to improve data collection, the REDC Consortium supports the Evaluating Disparities and Outcomes of Telehealth During the COVID-19 Emergency Act of 2021 or EDOT (H.R. 4770) which would also help provide rapid expansion to Medicaid and Medicare telehealth services benefits by studying data on fraud, utilization, and expenditures/savings. CMS's proposal would benefit from EDOT as it will also put a high importance on health equity by breaking down the utilization date by site of care, type of technology, type of service, and demographic factors, including age, gender, race, disability, status, and income. We encourage the agency to review H.R. 4770 to explore ways this PFS proposed rule could implement some of the provisions from this legislation.

We support CMS's proposal of creating confidential reports that would allow providers to look at patient impact through a variety of data points including race and ethnicity, LGBTQ+, dual-eligible beneficiaries, disability, and rural populations. Not only will this give Medicare beneficiaries the autonomy to self-report, but it also lets hospitals and health care providers use the results to identify and

[22] Capital Link. Financial Impact of COVID-19 on Federally Qualified Health Centers. https://www.caplink.org/images/National_COVID-19_Infographic_-_UPDATED_FINAL.pdf
[23] Ibid.
[24] Simmons, Adelle; Chappel, Andre; Kolbe, Allison; Bush, Laina & Sommers, Benjamin. (March 16, 2021). Health Disparities By Race and Ethnicity During the COVID-19 Pandemic: Current Evidence and Policy Approaches Issue Brief. Assistant Secretary For Planning and Evaluation. Retrieved from https://aspe.hhs.gov/system/files/pdf/265206/covid-equity-issue-brief.pdf

develop strategies to promote health equity. Access to data collection will help inform future telehealth policy and help to close the gaps in health equity.

V. Conclusion

Access to quality, equitable, and comprehensive care via telehealth is of critical importance to the work of the REDC Consortium and a key pillar for successful health outcomes for our patients and the nation. Treatment delivered via telehealth remains a necessary and lifesaving resource for individuals and families with mental health conditions. Codifying several of the flexibilities that have been offered during the PHE and foregoing any arbitrary barriers to care will greatly benefit the over 51 million individuals that have a mental illness in the U.S.[25]Overall, we are supportive of the bulk of the proposed changes for the 2022 plan year and urge CMS to strongly take into consideration the removal of a six month in-person requirement for patients to seek mental health care.

We look forward to reviewing the finalized rule and continuing to work together to improve access and quality healthcare to all Americans.

Sincerely,

ACUTE Center for Eating Disorders Colorado – Denver
Alsana Alabama – Birmingham
Alsana California – Monterey
Alsana California – Santa Barbara
Alsana California – Westlake Village
Alsana Missouri – St. Louis
Carolina House North Carolina – Durham
Carolina House North Carolina – Raleigh
Center for Change Idaho – Boise
Center for Change Utah – Cottonwood Heights
Center for Change Utah – Orem
Center for Discovery California – Beverly Hills
Center for Discovery California – Danville
Center for Discovery California – Del Mar
Center for Discovery California – Fremont
Center for Discovery California – Glendale
Center for Discovery California – Granite Bay
Center for Discovery California – La Habra
Center for Discovery California – La Jolla
Center for Discovery California – Lakewood
Center for Discovery California – Los Alamitos
Center for Discovery California – Menlo Park
Center for Discovery California – Newport Beach
Center for Discovery California – Pleasanton
Center for Discovery California – Rancho Palos Verdes
Center for Discovery California – Sacramento
Center for Discovery California – San Diego
Center for Discovery California – Temecula
Center for Discovery California – Thousand Oaks
Center for Discovery California – Torrance
Center for Discovery California – Woodland Hills

[25] National Alliance on Mental Illness. (2019). Mental Health By The Numbers. Retrieved from https://www.nami.org/mhstats.

Center for Discovery Connecticut – Fairfield
Center for Discovery Connecticut – Fairfield/Wellington
Center for Discovery Connecticut – Greenwich
Center for Discovery Connecticut – Southport
Center for Discovery Florida – Maitland
Center for Discovery Florida – Monteverde
Center for Discovery Florida – North Palm Beach
Center for Discovery Florida – Tampa
Center for Discovery Georgia – Atlanta
Center for Discovery Georgia – Dunwoody
Center for Discovery Illinois – Chicago
Center for Discovery Illinois – Des Plaines
Center for Discovery Illinois – Glenview
Center for Discovery Maryland – Columbia
Center for Discovery New Jersey – Bridgewater
Center for Discovery New Jersey – Paramus
Center for Discovery New York – Hamptons
Center for Discovery Oregon – Portland
Center for Discovery Texas – Addison
Center for Discovery Texas – Austin
Center for Discovery Texas – Cypress
Center for Discovery Texas – Houston
Center for Discovery Texas – Plano
Center for Discovery Virginia – Alexandria
Center for Discovery Virginia – Fairfax
Center for Discovery Virginia – McLean
Center for Discovery Washington – Bellevue
Center for Discovery Washington – Edmonds
Center for Discovery Washington – Enumclaw
Center for Discovery Washington – Tacoma
Eating Disorders Treatment Center New Mexico – Albuquerque
Eating Recovery Center California – Sacramento
Eating Recovery Center Colorado – Denver
Eating Recovery Center Illinois – Chicago
Eating Recovery Center Illinois – Oak Brook
Eating Recovery Center Maryland – Towson
Eating Recovery Center Ohio – Cincinnati
Eating Recovery Center Texas – Austin
Eating Recovery Center Texas – Houston
Eating Recovery Center Texas – San Antonio
Eating Recovery Center Texas – Plano
Eating Recovery Center Texas – The Woodlands
Eating Recovery Center Washington – Bellevue
Eden Treatment Center Nevada – Las Vegas
Evolve Wisconsin – Appleton
Evolve Wisconsin – DePere
Evolve Wisconsin – Green Bay
Evolve Wisconsin – Oshkosh
Evolve Wisconsin – Stevens Point
Fairhaven Tennessee – Cordova
Fairwinds Florida – Clearwater
Farrington Specialty Counseling Indiana – Fort Wayne
Focus Treatment Centers Tennessee – Chattanooga
Focus Treatment Centers Tennessee –Knoxville
Gaudiani Clinic Colorado – Denver
Living Hope Eating Disorder Treatment Center Arkansas
Living Hope Eating Disorder Treatment Center Oklahoma

Magnolia Creek Alabama – Columbiana
McCallum Place Kansas – Overland Park
McCallum Place Missouri – St. Louis
Montecatini California – Carlsbad
Monte Nido California – Agora Hills
Monte Nido California – Malibu
Monte Nido Illinois – Winfield
Monte Nido Maryland – Glenwood
Monte Nido Massachusetts – Boston
Monte Nido New York – Irvington
Monte Nido New York – Long Island
Monte Nido New York – Rochester
Monte Nido Oregon – Eugene
Monte Nido Oregon – West Linn
Opal Food & Body Wisdom Washington – Seattle
Rosewood Arizona – Wickenburg
Rosewood Arizona – Tempe
Selah House Indiana – Anderson
SunCloud Illinois – Lincoln Park
SunCloud Illinois – Naperville
SunCloud Illinois – Northbrook
The Emily Program Minnesota – Duluth
The Emily Program Minnesota – Minneapolis
The Emily Program Minnesota – St. Louis Park
The Emily Program Minnesota – St. Paul
The Emily Program Ohio – Cleveland
The Emily Program Ohio – Columbus
The Emily Program Pennsylvania – Pittsburgh
The Emily Program Washington – Seattle
The Emily Program Washington – South Sound
The Emily Program Washington – Spokane
The Renfrew Center California – Los Angeles
The Renfrew Center Florida – Coconut Creek
The Renfrew Center Florida – Orlando
The Renfrew Center Florida – West Palm Beach
The Renfrew Center Georgia – Atlanta
The Renfrew Center Illinois – Chicago
The Renfrew Center Maryland – Towson
The Renfrew Center Maryland – Bethesda
The Renfrew Center Massachusetts – Boston
The Renfrew Center New Jersey – Mount Laurel
The Renfrew Center New Jersey – Paramus
The Renfrew Center New York – New York
The Renfrew Center New York – White Plains
The Renfrew Center North Carolina – Charlotte
The Renfrew Center Pennsylvania – Philadelphia
The Renfrew Center Pennsylvania – Pittsburgh
The Renfrew Center Pennsylvania – Radnor
The Renfrew Center Tennessee – Nashville
Timberline Knolls Illinois – Lemont
Timberline Knolls Illinois – Orland Park
Veritas Collaborative Georgia – Atlanta
Veritas Collaborative North Carolina – Charlotte
Veritas Collaborative North Carolina – Durham
Veritas Collaborative Virginia – Richmond
Walden Behavioral Care Connecticut – Guildford
Walden Behavioral Care Connecticut – South Windsor
Walden Behavioral Care Georgia – Alpharetta
Walden Behavioral Care Georgia – Dunwoody

Walden Behavioral Care Massachusetts – Amherst
Walden Behavioral Care Massachusetts – Braintree
Walden Behavioral Care Massachusetts – Dedham
Walden Behavioral Care Massachusetts – Peabody
Walden Behavioral Care Massachusetts – Waltham
Walden Behavioral Care Massachusetts – Westborough