01/14/2022

Hello REDC Members,

Here is this week's policy update.

REMINDER! Survey on Access to In-Network MH/SUD Care—please participate and share!

- Survey Link: https://survey.amerispeak.org/SE/?st=tT6ZyQXGSUOdUeS0y8aFxJCpGXOkqy5R0UUFOl2sASI%3d&urlimport=1&questlist=PVD&PVD=58

- The Bowman Family Foundation in collaboration with NAMI and NORC (a nonpartisan research institute at the University of Chicago) is conducting a survey to address topics such as:
    - Whether MH or SUD care was needed and not received and why;
    - The impact of the COVID pandemic on (a) MH and SUD conditions and (b) access to care
    - The frequency of, and reasons for, use of out-of-network providers
    - "Search times" and "wait times" to access in-network providers
    - Insurance denial rates for MH and SUD care
    - The use of views about (a) tele-behavioral care and (b) apps for MH/SUD care

Health Insurance

- **ACA 2023 Notice of Benefit and Payment Parament Proposed Rule**
- **Please be on the lookout for a template comment and step-by-step insructions for your respective treatment center to fill out on Thursday, January, 20, 2022.**
    - **The deadline to submit comments is by 5pm EST on Thursday, January 27, 2022.**
    - **Reminder!** Regulatory comment submissions are a numbers game and the more comments they can receive that reiterate key points, the better chance we have in making our requests a reality!

- **ACA Enrollment**
    - 14.2 million people have signed up for private health insurance coverage under the ACA during this year's open enrollment period.
        - This marks a 21% increase over last year.
        - The figure includes more than 9.7 million people who enrolled or were automatically re-enrolled in the 33 states that use HealthCare.gov, the federal marketplace, and more than 4 million people in states that run their own exchange.

            - Open enrollment for Healthcare.gov ends tomorrow (Saturday).

- **High Deductible Health Plans (HDHPs) and Health Savings Accounts (HSAs)**
    - The REDC signed onto a letter led by the Alliance for Connected Care urging Congress to reinstate virtual care access that enabled employers and health plans to provide pre-deductible coverage for telehealth services for individuals with HDHP-HSA plans.
    - Attached is the final letter that includes over 100 organizations in support of this issue.
    - The Alliance for Connected Care have also put out a press release that can be viewed here.

- **Medicare Payment Advisory Commission (MedPac) Advances 2023 draft recommendations**
    - MedPac greenlit 2023 draft recommendation aimed at bolstering data on telehealth usage.
        - The first recommendation was a claims modifier to mark audio-only telehealth, aimed at enabling analysis of audio-only visits' quality and cost.
            - Other recommendations require hospice providers and home health agencies to report telehealth use.
        - MedPac is required to send its recommendations to Congress in March.

No Surprises Act Implementation

- **Flagging Potentially Problematic Provisions**
    - The No Surprises Act was a large bill that passed last Congress to address billing issues among many other items.
        - The REDC Consortium led the work to remove a harmful timely billing provision that would severely weaken the ability for treatment sites and providers alike to appeal claims. We were successful in this provision being stripped from the final bill.
    - The implementation of the remaining provisions of the bill are being rolled out by the Biden Administration and has caused much turmoil for providers. So much turmoil that the American Hospital Association and the American Medical Association are suing to stop the implementation of this law.
        - We wanted to flag a couple items we are monitoring that could negatively impact providers in the MHSUD space. These two items are summarized below for your reference.
    - **Good Faith Estimate (GFE) for Self-Pay or Uninsured**

i. Requires a provider must provide a GFE for services to an uninsured or self-pay patient upon request or upon scheduling services.

1. Definition of what constitutes a patient request is “any discussion or inquiry” about the cost of services from the patient per the Department.
2. GFE’s are also required to be available in writing and prominently displayed on the provider’s website, in the provider’s office and on-site where scheduling or questions about the cost of items or services occur.
3. When a provider furnishing a GFE anticipates there will be additional services that will require separate scheduling and not reflected in the current GFE, the provider must list these services in the GFE.

ii. Issues:

1. Specifically for the behavioral health field, many providers won’t be able to accurately estimate the needs of a patient until they physically see them or have a telehealth appointment, and receive vitals to determine the extent of treatment they made need.
2. Many providers have dedicated financial offices that assist uninsured patients about the costs of services and navigating payment. This could lead to burdensome GRE requests from patients to staff that were typically handled by other channels via online or with a financial office liaison.
3. Requiring a provider to list services for a patient outside of their specialty of care and associated costs can create immense confusion for the patient and put the provider in a difficult position to accurately predict all of the health needs for a patient. Further, it is not uncommon for the uninsured to not have an established relationship with providers, which complicates communication and understanding even further.

iii. Here is the latest FAQ that came out regarding this: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf

- **Advanced Explanation of Benefits (EOB) for Insured Patients**

i. Importantly, this has been delayed by the Administration, but essentially would require all commercial insurer to put together an EOB prior to seeing the patient in an effort.

ii. Issues:

1. Again, how can a provider possibly know what is needed for a particular patient with a behavioral health condition and/or co-occurring conditions?
2. It could deter care if the insurers are deluged with requests and can't process this fast enough or if it is inaccurate what they will cover a patient may just forgo care all together.

SERVE Act

- The SERVE Act is now part of Public Law No: 117-81!
- We are currently working on a letter from REDC to the Department of Defense to encourage speedy implementation that is aligned with our and Congress' intent.

Have a great weekend!

Center Road Solutions Team