REDC
Highest Standards of Care

January 25, 2022

Chiquita Brooks-LaSure, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Humans Services
Attention: CMS-9911-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via regulations.gov

RE: RIN 0938-AU65; CMS-9906-P
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023 Proposed Rule

Dear Administrator Brooks-LaSure:

On behalf of the REDC Consortium please accept the written comments below in response to the proposed rule "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023" or the NBPP Rule. The REDC Consortium is a national trade association of eating disorder treatment centers, representing approximately 85% 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 disorder, and other specified feeding or eating disorders.[4] These disorders are unique in that they co-occur

[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.
[4] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5.* Washington, D.C: American Psychiatric Association.

and can lead to several mental health and medical complications. For example, 25% 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]

The COVID-19 pandemic has exacerbated eating disorders across the nation as REDC members have seen a 30-100% increase in demand for care, with call volumes and inquiries for care doubling, significantly increased acuity in nature of illness individuals present with and wait times expanding from 1 week to 6-8 months in some areas of the country (REDC Member Survey, 2021).

Increasingly troubling is the increase in pediatric and adolescent health needs, including eating disorders. Hospitals across the nation are reporting the inability to keep up with demand as St. Louis Children's Hospital in Missouri is seeing 8-15 kids per day for behavioral health issues including suicide attempts, eating disorders, anxiety, and psychosis.[8] At C.S. Mott Children's Hospital in Michigan, administrators found medical admissions among adolescents with eating disorders during the first 12 months of the pandemic more than doubled the mean for the previous 3 years.[9] At Arkansas Children's, the hospital has seen a 150% increase in mental health disorder emergency room admissions.[10] Arkansas Children's CEO, Marcy Doderer recently stated "intense inpatient residential treatment for eating disorders is not available in the state of Arkansas. So that's one of the services we're evaluating [to see if] we can bring it back to the state."[11]

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% of patients will relapse and are two times more likely to end up in the emergency room than someone without an eating disorder.[12] The U.S. economic impact of these eating disorder readmissions amount to $29.3 million in emergency room visits annually and $209.7 million

[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] Onge, Kim. (July 15, 2021). Missouri facing pediatric behavioral health crisis; hospitals running out of beds for kids. News 4 St. Louis. Retrieved from https://www.kmov.com/news/missouri-facing-pediatric-behavioral-health-crisis-hospitals-running-out-of-beds-for-kids/article_cf9d6e00-e510-11eb-9df3-b7371bcd1e44.html.
[9] Otto, A; Jary, J; Sturza, J; Miller, C; Prohaska, N; Bravender, T & Jessica Van Huyssee. Medical admissions among adolescents with eating disorders during the covid-19 pandemic. *Pediatrics* 2021; 148; DOI: 10.1542/peds.2021-052201
[10] Jensik, Lauren. (September 27, 2021). Arkansas Children's CEO says mental illness-related ED visits have jumped 150% during pandemic. Becker's Hospital Review. Retrieved from https://www.beckershospitalreview.com/hospital-management-administration/arkansas-children-s-ceo-says-mental-illness-related-ed-visits-have-jumped-150-during-pandemic.html
[11] Ibid.
[12] 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

for inpatient hospitalizations annually.[13] 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.[14]

In turn, we support the proposed changes in the NBPP Rule to safeguard consumers and ensure they're able to receive the coverage and care they need. In our comments below you will find several supportive statements related to the proposed rule and information to take into consideration to strengthen ACA plans further in plan year 2023 and beyond. 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, FAED
President, REDC Consortium

[13] 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/.
[14] Ibid.

I. Refine EHB Nondiscrimination Policy for Health Plan Designs (§156.125)

REDC members strongly support the proposed revisions within the NBPP Rule that seeks to eliminate discriminatory benefit designs through the use of a regulatory framework based on clinical evidence that includes relevant peer-reviewed medical journal articles, practice guidelines, recommendations among reputable governing bodies, or similar sources.[15] Additionally, we agree that states may be able to utilize this regulatory framework to supplement their own enforcement efforts. In addition to the journals outlined in the proposed rule, **we would also urge the inclusion of the *International Journal of Eating Disorders*, *Journal of Adolescent Health*, and the *Journal of the Academy for Nutrition and Dietetics*. Additionally, we recommend the use of the American Society for Addiction Medicine (ASAM) Criteria**[16] **and the REDC Consortium's Level of Care Criteria**[17] **for objective, clinical guidelines for the treatment of addiction and eating disorders.**

Individuals and families with behavioral health needs are frequently discriminated against. Since the historic passage of the Mental Health Parity and Addiction Equity Act in 2008, incompliance by insurance companies continues. Individuals and families with behavioral health conditions are victim to the most egregious violations of the law. For example, the landmark 2019 *Wit v. United Healthcare Insurance Company* case featured Natasha Wit as the main plaintiff who sought coverage for treatment of multiple chronic conditions, including a severe eating disorder and was repeatedly denied treatment by UBH (United Behavioral Healthcare).[18] The 11 plaintiffs in the case represented over 50,000 patients who were denied care under UBH discriminatory policies, and the judge ruled in favor of the plaintiffs.[19]

In addition to the examples of discriminatory benefit designs, benefit limitations, and plan coverage requirements noted in the proposed rule, **another example of discriminatory benefit limitations relates to medical nutrition therapy (MNT).** Outpatient medical nutrition therapy (MNT) services are covered *only* for individuals diagnosed with diabetes or end-stage renal disease. Although the majority of eating disorder patients are treated in the outpatient setting with a multidisciplinary approach between the patient, a therapist, a psychiatrist, a physician, and a dietitian,[20] critical MNT services are not available to this patient population. The American Psychiatric Association (APA) and the National Institute for Clinical Excellence (NICE) have stated the first goal of treatment for anorexia nervosa is weight restoration.[21] Further, studies show nutritional interventions along with psychological and psychiatric treatment are effective in improving eating behaviors.[22] This critical proposed regulatory framework would finally provide MNT coverage for individuals with eating disorders.

Further, discriminatory benefit limitations have entered the telehealth space. Starting April 1, 2022 BlueCross BlueShield Massachusetts will be cutting telehealth reimbursement rates for MNT

[15] Centers for Medicare & Medicaid, HHS (2022). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Paraments for 2023, p. 223. Retrieved from https://public-inspection.federalregister.gov/2021-28317.pdf
[16] American Society for Addiction Medicine. ASAM Criteria. https://www.asam.org/asam-criteria. Accessed on January 18, 2022.
[17] REDC Consortium. Standards. Retrieved from: https://redcconsortium.org/standards/. Accessed on January 18, 2022.
[18] Kennedy, Patrick & Ramstad, Jim. (2019). Landmark ruling sets precedent for parity coverage of mental health and addiction treatment. Stat News. Retrieved from https://www.statnews.com/2019/03/18/landmark-ruling-mental-health-addiction-treatment/
[19] Ibid.
[20] Lewis & Ellis, Inc. (2013). Report For The Joint Committee On Legislative Research Oversight Division Regarding Actuarial Services Review Of Senate Bill 262, Senate Bill 159, And Senate Bill 161.
[21] Marzola, E., Nasser, J., Hashim, S., Pei-an, B., and Kaye, W. (2013). Nutritional rehabilitation in anorexia nervosa: review of the literature and implications for treatment. *BMC Psychiatry*, 13:290.
[22] Ruiz-Prieto, Inmaculada, Bolanos-Rios, Patricia and Jauregui-Lobera, Ignacio. (2013). Diet Choice in weight-restored patients with eating disorders; progressive autonomy by nutritional education. *Nurtricion Hospitlaria,* 28:5, 1725-1731.

services by 20% for select conditions the company does not deem a "chronic condition" (L. Lieberman, personal communication, January 11, 2022). All eating disorder subtypes, celiac disease, and irritable bowel syndrome did not make the list. This stunning decision fails to account for the patient and provider relationship, especially in the context of a pandemic. Currently, telehealth sessions are more "face-to-face" then in-person, masked sessions. Via video, patients and providers can see each other's facial expressions to aid in support and communication, critical for the work dietitians do. This is absent in so called face-to-face, masked in-person encounters, which are being preferentially covered. This arbitrary policy also fails to consider the medical needs of providers that are still providing care but may be immunocompromised and prefer telehealth visits while the pandemic continues to thrive and mutate across the country.

Similarly, there is great concern that once the nation is not in a state of emergency, more insurers will scale back payment parity or telehealth coverage at specific levels of care. We estimate that 75% of our members are delivering care via telehealth in addition to providing in-person services at our brick-and-mortar facilities. A study released in the *International Journal of Eating Disorders* in December 2021 compared in-person versus virtual therapy in outpatient eating disorder treatment finding short-term clinical outcomes (i.e., eating symptoms, levels of weight gain (as applicable), and patient satisfaction with services) were comparable.[23] Virtual therapy can fill a need where geographical distance or other barriers impede physical access to specialized MHSUD treatments.[24] This latest study joins a growing body of evidence showing there are no statistically significant differences in providing outpatient and intensive outpatient eating disorder care in a virtual or in-person setting.[25,26]

The findings underscore what we have seen in our treatment centers every day since the onset of the pandemic. 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. **We remain increasingly concerned that payers will end telehealth coverage and remove access to medically necessary treatment for individuals.** We have seen this tenuous situation morph throughout the pandemic as the nation's largest insurer, Optum/UnitedHealth Group announces termination of coverage for PHP/IOP telehealth every 90 days and then resumes coverage approximately a week passed the termination date. For example, Optum/UnitedHealth Group had a PHP/IOP telehealth coverage terminate date of September 30, 2021, then extended that date to December 31, 2021, we received formal confirmation they once again extended the termination date to April 1, 2022 on January 7, 2022.[27] These arbitrary termination deadlines are not based on any clinical rationale and harm patients and families when our providers have to communicate these coverage lapses. Further, the arbitrary coverage patches impede care coordination, transition care planning, and add to the stress on the patient, their family, and treatment team.

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[23] Steiger, H., Booij, L.; Crescenzi, O.; Oliverio, S., Singer, I.; Thaler, L.; St-Hilarie, A., Israel, M. In-person versus virtual therapy in outpatient eating-disorder treatment: A COVID-19 inspired study. *Int J Eat Disord.* 2021 December 14. https://doi.org/10.1002/eat.23655

[24] Ibid.

[25]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.

[26] 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

[27] Optum Provider Express. COVID-19 IOP/PHP Telehealth Policy Updates. Retrieved from https://www.providerexpress.com/content/ope-provexpr/us/en/COVID-19_Provider_Updates/COVID-19_IOP-PHP_Telehealth_Policies.html

II. Nondiscrimination Based on Sexual Orientation and Gender Identity

REDC members support the proposed NBPP Rule to amend 45 CFR 155.120(c) to explicitly prohibit discrimination based on sexual orientation and gender identity. Research has shown that youth identifying as LGBTQI+ report higher levels of sexual-specific victimization, depressive symptoms, and suicidality compared to their heterosexual peers.[28] Additionally, LGBTQI+ individuals experience higher levels of stigma and are more likely to report eating disorder symptoms, and that shame, concealment of one's sexual identity, and discrimination increases the risk of eating disorders.[29] Further, research has indicated that approximately 54% of LBGTQI+ adolescents have been diagnosed with a full-syndrome eating disorder during their lifetime.[30]

The REDC Consortium is committed to providing gender-inclusive care to all of our patients. We are proud to offer several eating disorder treatment facilities and programs tailored to the LBTQI+ community. We support the NBPP Rule that explicitly states the clinical evidence to support medically necessary gender affirming care and that plan designs must cover these services.

III. Network Adequacy (§ 156.230)

The REDC appreciates and supports CMS' work in finding solutions to address the challenging topic of network adequacy, especially in the MHSUD field. We support the proposed guardrails to determine network adequacy including guidance for insurers to begin tracking telehealth availability within plan offerings. Although distance metrics and wait time for appointments are strong parameters for determining network adequacy, we also encourage guardrails around adequate reimbursement, ensuring any guardrails also apply to third-party administrators (TPAs), and takes into consideration levels of care. **Sixteen states have adopted specific quantitative metrics for determining network adequacy for MHSUD, and their metrics could be used as models to develop federal metrics.[31]**

A 2019 Milliman report[32] examined in network use and provider reimbursement for MHSUD versus physical health and found staggering disparities including:

- 85% increase in how often behavioral inpatient facilities are utilized out of network relative to medical/surgical providers in a 5-year study period.
- Out of network utilization rate for behavioral health residential treatment facilities was over 50%.
- Primary care reimbursement rates were 23.8% higher than behavioral health reimbursements.
- A behavioral healthcare office visit for a child was 10.1 times more likely to be out of network than a primary care office visit.
    - This is more than twice the disparity seen for adults.

[28] Parker, L. & Harriger, J. Eating disorders and disordered eating behaviors in the LGBT population: a review of the literature. *Int J Eat Disord 8, 51* 2020 October 16. https://doi.org/10.1186/s40337-020-00327-y
[29] Ibid.
[30] Ibid.
[31] Legal Action Center & Partnership to End Addiction. (May 1, 2020). Spotlight on network adequacy standards for substance use disorder and mental health services. Retrieved from: https://www.lac.org/assets/files/Network-Adeqaucy-Spotlight-final-UTO.pdf
[32] Melek, S., Davenport, S., & Gray, T.J. (November 19, 2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. Milliman Research Report. Retrieved from https://www.milliman.com/-/media/milliman/importedfiles/ektron/addictionandmentalhealthvsphysicalhealthwideningdisparitiesinnetworkuseandproviderreimbursement.ashx

i. Reimbursement

Given the immense mental health needs in the U.S., these disparities are simply unacceptable. Unfortunately, we are unable to address network adequacy without addressing reimbursement in the MHSUD field. It is not uncommon for our providers to go out of network given reimbursement disparities. For example, one of our member sites decided to go out of network given the payor offered a $19 per day reimbursement for a partial hospitalization program that provides 8 hours of care. That rate does not even cover the cost of food for the site's programming (B. Farrington, personal communication, February 21, 2021). It is not an exaggeration to say that remaining in network would render many of our treatment facilities to go out of business.

ii. Third-Party Administrators

A trend that is concerning for our treatment sites relates to TPAs including, but not limited to, United Medical Resources (UMR), Golden Rule, United Health, and Allsavers have considerable amounts of unpaid balances due to review of the patient's medical records, appeal, and then determination that the level of care was not medically necessary. When are members sites discuss denials with the plan, they have stated the TPAs are not within their authority to oversee as TPAs just "rent their network". Below is an example of how these communications unfold:

- The TPA does not require authorization or concurrent review prior to a provider administering care. The TPA subsequently denies a claim because it did not go through authorization.
    - The TPA then requests a review of the medical records and moves into a medical record review cycle. The TPA physicians review and deny level of care, in a few circumstances the physician reports the next level down is what is necessary.
        - REDC member site appeals stating the TPA should at least pay for the level of care deemed necessary rather than outright deny the entire stay and those appeals have been unsuccessful.
    - The stay/claim is denied as a member liability, which is odd, because as a contracted provider typically a member would not be held responsible.
        - Patients and families who have the wherewithal to be involved and file a member appeal have with few exceptions had the denial overturned.

We strongly urge that for any plan that rents out their network to a TPA, the plan is then responsible and held accountable of any claims that are submitted through their network—rented or not. This also means the TPA must follow any guardrails that the plan follows under the Affordable Care Act.

iii. Levels of Care

As part of network adequacy standards, plans should have to cover all levels of care, which includes inpatient, residential, partial hospitalization, intensive outpatient, and outpatient. Given the complexity of eating disorders treatment there are several states where eating disorders treatment does not exist. Although we agree with earlier commentary within the NBPP Rule that payors should not construe the proposed rule to mean that telehealth services could be counted in place of in-person service access for the purpose of network adequacy standards,[33] telehealth does serve as an additive tool in providing specialized,

[33] Centers for Medicare & Medicaid, HHS (2022). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Paraments for 2023, p. 271. Retrieved from https://public-inspection.federalregister.gov/2021-28317.pdf

multidisciplinary treatment to those in need where it may not be available locally. We see the immense value in our in-person services and virtual services. For example, one of our member sites not only utilizes their brick-and-mortar location for patients in need of higher-level care, the site also pairs Medicaid patients in-person vital sign check-up with food pantry pick up for those experiencing food and/or nutrition insecurity.

For the MHSUD field, telehealth expansion as a result of the COVID-19 pandemic has filled a large gap in access to care. Over the course of the pandemic, we have had to advocate for continued telehealth coverage from a variety of commercial payors to maintain virtual coverage for partial hospitalization and intensive outpatient services. Although we have been successful in thwarting the termination of this coverage for now, we remain concerned payors have the ability to terminate coverage at any given time with no clinical evidence or drastically cut reimbursement to unsustainable levels. For these reasons, we strongly encourage integrating telehealth as **a covered treatment modality for essential health benefits.** Under 42 U.S. Code § 18022, the Secretary has the authority to review EHBs and modify the benefits based on changes in medical evidence or scientific advancement. For the MHSUD fields, this would bring needed certainty in our fields for continuing to treat patients via telehealth as appropriate.

IV. Additional Support and Comments

i. Solicitation of Comments—Choice Architecture and Preventing Plan Choice Overload

We agree with the NBPP Rule to standardize plan options within each metal level for consumers that utilize Healthcare.gov. We also agree to resume differential display of standardized plans on Healthcare.gov and extend this policy to web-brokers and insurers that use direct enrollment. Last, we support the Department exploring a limit on the number of plans an insurer can offer for future plan years.

Shopping for health insurance can be immensely complicated as approximately 73% of Healthcare.gov consumers have more than 60 plan options to choose from.[34] The number of plans has exploded in recent years with an average number of over 100 plans.[35] The sheer number of options can be overwhelming for a consumer and lead to further confusion about what plan best suits their needs and/or the needs of their family. The proposed changes would better support consumers through improved transparency, standardization, and differential placement on sites.

ii. Guaranteed Availability of Coverage (§ 147.104(i))

We support reversing the policy which allows an insurer to refuse enrollment of a consumer if the consumer has outstanding premium debt from the previous year. Consumers should not be dissuaded to enroll in coverage and do not need additional barriers in accessing health care.

The amount of past due premiums owed to payors we consider are nominal compared to profits. UnitedHealth Group reported $4.9 billion in the first quarter of 2021—a 44% increase from 2020, Anthem reported profits of $1.67 billion—a 9.5% increase from 2020, and CVS Health reported profits of $2.2

[34] Chu, R., Rudich, J., Lee, A., Peters, C., De Lew, N., & Sommers, B. (December 28, 2021). Facilitating consumer choice: Standardized Plans in Health Insurance Marketplace. Assistant Secretary for Planning and Evaluation. Retrieved from https://aspe.hhs.gov/sites/default/files/documents/222751d8ae7f56738f2f4128d819846b/Standardized-Plans-in-Health-Insurance-Marketplaces.pdf
[35] Ibid.

billion—a $200,000 increase from 2020.[36] Americans do not need additional barriers or punitive measures in place to access healthcare.

V. Conclusion

Access to quality and comprehensive care that includes MHSUD treatment 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.

We thank the Department for the opportunity to provide feedback on this issue and the thoughtful consideration put into the NBPP Rule to improve affordable, accessible, inclusive, and comprehensive care for Americans. 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
Center for Discovery Connecticut – Fairfield

[36] Holpuch, Amanda. (May 8, 2021). US health insurers report billions in first quarter as small providers face stress. *The Guardian.* Retrieved from https://www.theguardian.com/business/2021/may/08/us-health-insurance-companies-2021-first-quarter.

Center for Discovery Connecticut – Fairfield/Wellington
Center for Discovery Connecticut – Greenwich
Center for Discovery Connecticut – Southport
Center for Discovery Florida – Dade City
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 Maryland – Crownsville
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
Prosperity Eating Disorders and Wellness Centers – Herndon, Virginia
Prosperity Eating Disorders and Wellness Centers – Norfolk, Virginia
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