Date: May 13, 2022
To: REDC Consortium
From: Center Road Solutions
RE: Final Rule of the Notice of Benefit and Payment Parameters for 2023

In January 2022, the REDC Consortium submitted comments to the Centers for Medicare and Medicaid Services in response to the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023. This annual rule is the regulatory framework CMS uses to operate Affordable Care Act health plans.

To bolster support of our comments, REDC member sites Eating Recovery Center, SunCloud Health, Farrington Specialty Centers, Walden Behavioral Healthcare, The Emily Program, Veritas Collaborative, Renfrew Center, and Timberline Knolls submitted their own comments. Additionally, the International Federation of Eating Disorder Dietitians and the following dietitian practices Big Picture Nutrition LLC, Liz Brown Nutrition LLC, Eliza Heberlein, Heal and Hope Nutrition, and Bamboo Nutrition submitted their own comments.

The final rule was released on May 6, 2022 and the following information provides a detailed explanation comparing what REDC recommended and what was ultimately finalized.

I. Refine EHB Nondiscrimination Policy for Health Plan Designs

REDC Recommendation: 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.

Urge the inclusion of the *International Journal of Eating Disorders*, *Journal of Adolescent Health*, and the *Journal of the Academy for Nutrition and Dietetics as additional journals that can be utilized*. Additionally, we recommend the use of the American Society for Addiction Medicine (ASAM) Criteria[1] and the REDC Consortium's Level of Care Criteria[2] for objective, clinical guidelines for the treatment of addiction and eating disorders in addition to journals listed in the proposed rule.

Last, take into consideration discriminatory benefit design as it relates to telehealth vs. in-person care.

Final Rule (Partial Victory): Effective January 1, 2023, HHS will require a nondiscriminatory benefit design providing essential health benefits (EHBs) be one that is clinically based and does not discriminate based on age, expected length of life, present, or predicted disability, degree of medical dependency, quality of life, or other health conditions.

Unfortunately, HHS has declined to finalize that a nondiscriminatory benefit design that provides EHBs must incorporate evidence-based guidelines into coverage and rely on current and relevant peer-reviewed medical journal articles, practice guidelines, recommendations from reputable governing bodies, or the related examples of acceptable sources included in the preamble of the proposed rule.

The agency also declines to include any specific ''standard of care'' within a list of appropriate clinical evidence that issuers may rely upon. HHS is of the view that the requirements of this rule and the guidance provided are sufficient to enable issuers to set coverage limitations that comply with the EHB requirements.

[1] American Society for Addiction Medicine. ASAM Criteria. https://www.asam.org/asam-criteria. Accessed on January 18, 2022.
[2] REDC Consortium. Standards. Retrieved from: https://redcconsortium.org/standards/. Accessed on January 18, 2022.

The agency asserts requiring plan designs providing EHB to be clinically based, without these additional requirements, is sufficient to protect consumers from discriminatory benefit designs. CMS will reassess whether refining this standard in future rulemaking is warranted as they continue to monitor issuer compliance with the nondiscrimination standards.

Regarding telehealth oversight, the agency encourages commenters to work with States to help ensure consistent coverage. The agency intends to monitor telehealth utilization as it pertains to the delivery of benefits and how the utilization of telehealth may impact nondiscriminatory access to EHB.

II. Network Adequacy

REDC Recommendation: We support the proposed guardrails to determine network adequacy including time and distance standards and 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.[3]

Final Rule (Partial Victory): For certifying Qualified Health Plans, HHS will adopt time and distance standards to strengthen network adequacy for QHPs offered on the Federally Facilitated Exchanges (FFEs). Appointment wait time and distance reviews will begin in PY 2024. The method for assessing compliance with these standards will be addressed in future rulemaking.

The agency also added the following provider specialties (Table 14 below) that would also comply with the distance and wait time reviews. Providers listed below must be appropriately licensed, accredited, or certified to provide services in their State, as applicable, and must have in-person services available. The expansion of provider specialty lists will push Qualified Health Plan networks to be more robust, comprehensive, and responsive to enrollee needs. In the future, HHS may engage with consumer groups on this topic to evaluate the appropriateness of appointment wait time standards for future rulemaking.

HHS considered removing the requirement that providers have in-person services available to count towards these standards since some behavioral health providers only offer services via telehealth. However, the agency wants to ensure that telehealth services do not displace the availability of in-person care. **Consequently, HHS is finalizing that to count towards the standards, providers must have in-person services available.**

Last, HHS is finalizing the requirement for issuers to submit information about whether providers offer telehealth services to begin informing the agency on the availability of telehealth within QHPs.

[3] 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

TABLE 14: Individual Provider Specialty List for Time and Distance Standards

Individual Provider Specialty Types
Allergy and Immunology
Cardiology
Cardiothoracic Surgery
Chiropractor
Dental
Dermatology
Emergency Medicine
Endocrinology
ENT/Otolaryngology
Gastroenterology
General Surgery
Gynecology, OB/GYN
Infectious Diseases
Nephrology
Neurology
Neurosurgery
Occupational Therapy
Oncology – Medical, Surgical
Oncology – Radiation
Ophthalmology
Orthopedic Surgery
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)
Physical Medicine and Rehabilitation
Physical Therapy
Plastic Surgery
Podiatry
Primary Care – Adult
Primary Care – Pediatric
Psychiatry
Pulmonology
Rheumatology
Speech Therapy
Urology
Vascular Surgery

III. Nondiscrimination Based on Sexual Orientation and Gender Identity

REDC Recommendation: 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. 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.

Final Rule: HHS proposed to amend these regulations to explicitly identify and recognize discrimination on the basis of sexual orientation and gender identity as prohibited forms of discrimination based on sex consistent with the Supreme Court's decision in Bostock v. Clayton County[4] and HHS nondiscrimination policy that existed prior to the 2020 regulatory amendments by the Trump Administration.

Currently, HHS is developing a proposed rule that also will address prohibited discrimination based on sex in health coverage under section 1557 of the ACA. **HHS is of the view that it would be most prudent to**

[4] 140 S. Ct. 1731 (2020)

address the nondiscrimination proposals related to sexual orientation and gender identity at a later time to ensure that they are consistent with the policies and requirements that will be included in the section 1557 rulemaking.

IV. Additional Support/Comments

REDC Recommendation: We agree 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.

Final Rule (Victory): Finalized as proposed.

REDC Recommendation: 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.

Final Rule (Victory): The current interpretation of this policy disincentivizes enrollment by conditioning coverage on the repayment of the past-due premium debt, which may deter individuals who have accrued past-due premium debt from seeking coverage altogether. Conversely, permitting individuals to enroll in coverage, regardless of past-due premium debt, will help ensure continuous access to health care, especially for individuals facing dire economic circumstances. The final rule reverses this policy.