REDC
Highest Standards of Care

November 8, 2021

The Honorable Ron Wyden
Senate Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Mike Crapo
Senate Committee on Finance
United States Senate
Washington, DC 20510

Submitted electronically to mentalhealthcare@finance.senate.gov from Allison Ivie (allison.ivie@centeroadsolutions.com) on behalf of the REDC Consortium

Dear Chairman Wyden and Ranking Member Crapo,

On behalf of the REDC Consortium, we thank you for the opportunity to provide comment regarding your Request for Information (RFI) on legislative proposals and ideas to improve access to behavioral health services for Americans. 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 (PHP), day program, and intensive outpatient treatment (IOP). We are proud to have member sites serving your states in Idaho and Oregon.

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.

Below you will find the REDC's recommendations, legislative proposals, and issues our provider force faces as it relates to strengthening the workforce, ensuring parity, and expanding telehealth.

I. Strengthening the Workforce

As the Committee is intimately aware, the U.S. continues to face a behavioral health care workforce shortage. According to HRSA projections, even with an increase in supply, the demand for behavioral health workers by 2030 include a 3% increase in demand for adult psychiatrists, 5% increase in demand for psychologists, a 15% increase in demand for addiction counselors, and a 13% increase in demand for mental health counselors.[1] Compounding this issue is the lack of specialized training for complex mental illnesses, like eating disorders. Comprehensive care for

[1] HRSA. Behavioral Health Workforce Projections. Accessed on November 3, 2021. https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/behavioral-health

eating disorders involves a multidisciplinary treatment team typically consisting of a psychiatrist, psychologist, medical doctor, and a dietitian. As we know, the pandemic has exacerbated mental health needs across the country. An ongoing study from the National Center of Excellence for Eating Disorders[2] found in July 2020, 62% of people in the U.S. with anorexia nervosa experienced a worsening of symptoms as the pandemic hit, and nearly one-third of Americans with binge eating disorder, which is far more common, reported an increase in episodes.

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). Our partner organizations like the National Eating Disorders Association saw a 40% increase in call volume the first year of the pandemic. The National Alliance for Eating Disorders saw a 108% increase in referrals and an 82% increase in support group attendance in 2020 and is on pace to surpass those figures in 2021 (J. Kandel, personal communication, May, 2021).

There has been an exorbitant increase in pediatric and adolescent mental health needs. 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.[3] At C.S. Mott Children's Hospital in Ann Arbor, 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.[4] At Arkansas Children's, the hospital has seen a 150% increase in mental health disorder emergency room admissions.[5] 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."[6] This uptick in mental health conditions has led the Children's Hospital Association, American Academy of Pediatrics, and the American Academy of Child and Adolescent Psychiatrists to launch "Sound the Alarm for Kids", which is an awareness campaign to increase funding to address this emergency.[7] The REDC Consortium was one of the initial groups who pledged our support in this effort. The impact on this demographic will be felt for years to come.

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[2] Termorshuizen, J; Watson, H; Thornton, L; Borg, S; Flatt, R; MacDermod, C; Harper, L; Van Furth, E; Peat, C; & Cynthia M. Bulik. Early Impact of COVID-19 on Individuals with Eating Disorders: A survey of ~1000 Individuals in the United States and the Netherlands. June 8, 2020. https://doi.org/10.1101/2020.05.28.20116301

[3] 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.

[4] 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

[5] 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

[6] Ibid.

[7] Ray, Gillian. (November 2, 2021). "Sound the alarm for kids" raises awareness of national mental health emergency in children and teens. Retrieved from https://www.childrenshospitals.org/Newsroom/Press-Releases/2021/Sound-the-Alarm-for-Kids.

Unfortunately, physicians and other health professionals are not adequately trained on how to identify and treat eating disorders. A study of 637 residency programs, 514 did not offer any scheduled or elective rotations for eating disorders.[8] Of the 123 programs that did offer eating disorder rotations, only 42 offered a formal, scheduled rotation.[9] The U.S. healthcare system is currently designed to respond to mental health crises and not invest in early intervention or ongoing management of a mental illness. This approach costs the U.S. $64.7 billion annually for individuals with eating disorders.[10] The federal government shoulders $17.7 billion of that annual cost.[11] Eating disorders crisis care results in $29.3 million in ER visits annually and $209.7 million in inpatient hospitalizations.[12] This does not have to be the reality for Americans or the U.S. economy.

Recommendations

- Incentivize strong reimbursement guardrails within ACA plans.
    - Commercial payers historically provide very low reimbursement rates for behavioral health services.
        - For example, one of our member sites has had to accept 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).

- Increase provider payments under Medicare, Medicaid, and CHIP for behavioral health care providers at parity with their medical/surgical colleagues.

- Provide coverage for medical nutrition therapy services under Medicare for individuals with an eating disorder diagnosis.
    - **Existing Legislation Recommendation:** Nutrition CARE Act (H.R. 1551/S. 584)

- Modify federal licensing and scope of practice requirements to reduce barriers for behavioral health care.
    - Compacts or waivers to allow for behavioral health treatment across state lines would enhance access to specialized eating disorders care. Considering a waiver system or compact with bordering states to start would be a strong first step.
        - **Existing Legislation Recommendation:** TREAT Act (H.R. 708/S. 168)

[8] Mahr F, Farahmand P, Bixler EO, Domen RE, Moser EM, Nadeem T, Levine RL, Halmi KA. A national survey of eating disorder training. Int J Eat Disord. 2015 May;48(4):443-5. doi: 10.1002/eat.22335.
[9] Ibid.
[10] 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/.
[11] Ibid.
[12] Ibid.

- Creation of a behavioral health care apprenticeship or incentive program for a select number of conditions with the highest need to continue to enhance the pipeline of specialized behavioral health care providers.

II. Ensuring Parity

Since MHPAEA's historic passage in 2008, incompliance remains among insurance companies. 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).[13] The 11 plaintiffs in the case represented over 50,000 patients who were denied care under UBH discriminatory policies.[14] Additionally, the House Appropriations Labor, Health and Human Services, and Education and Related Agencies FY22 Committee Report expressed concerns with the continued lack of oversight and compliance with the law. The committee report cited a 2019 GAO report that found lack of adherence extends beyond plans investigated by the DOL and includes plans over which HHS has oversight authority.[15]

Given Medicare, Medicaid and CHIP do not need to adhere to parity, progress is stunted. Specifically, Medicare does not cover residential, partial hospitalization (outside of a hospital), and intensive outpatient treatment for eating disorders. Further, it does not cover registered dietitian services or even an assessment from an eating disorder specialist or the provision of mental health crisis services. As Medicare historically sets the tone for what services other public health insurance and commercial insurance covers and reimburses for, Medicare inadequacies have been replicated within TRICARE and the commercial market. These inadequacies continue to be a disservice for individuals and families with behavioral health conditions.

Our member sites spend an inordinate amount of time advocating on behalf of their patients for coverage of their behavioral health needs. Commercial payers have devised a series of tactics to delay authorizing treatment or paying for care. Here are some examples (REDC Member Survey, August 2021):

- **Affiliates of large payors will have different claims processes than the traditional large payors.**
    - This results in the affiliate stating no prior authorization to deliver care is needed only to have the claim denied for medical necessity due to no prior authorization on file. Our providers are instructed to submit the medical records for further review

[13] 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/
[14] Ibid.
[15] U.S. House. Committee on Appropriations. Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Bill, 2022. Available from: https://docs.house.gov/meetings/AP/AP00/20210715/113908/HMKP-117-AP00-20210715-SD003.pdf; Accessed: 7/28/21.

and 98% of the time the entire claim is denied as not medically necessary. This occurs with in-network admissions with an in-network provider.
    - Large payor groups maintain they are not responsible for affiliate groups. These groups simply "rent" their network and relinquish any accountability.
    - For our patients that have the financial means and emotional stamina to hire legal counsel, they have been successful in having their claims overturned and paid.

- **Payors conducting medical reviews post discharge.**
    - Our member sites have been experiencing several post discharge medical record reviews by payors. This means that once a patient is discharged from treatment, a payor will notify the facility that they would like to review a medical record for a past patient to determine medical necessity—even though medical necessity was already approved. This has resulted in payors requesting post discharge recoupment of funds for patients no longer in our care.
        - One of our member sites was tasked with providing the medical records of 25 patients post discharge.
        - In some cases, these reviews have occurred as late as 1-3 years post discharge.
    - Alternatively, a payor could change benefit plan design after a payor has already paid a patient's claim. The payor gets in touch with a member facility to recoup payment regardless of timeframe based on this benefit change.

Recommendations

- Prohibit payor recoupments post discharge of a patient.

- Prohibit recoupment of payment based on a benefit plan design change mid-plan year.

- Additional resources to the Department of Labor for oversight of commercial plans to enforce parity.
    - **Existing Legislation:** Parity Enforcement Act (H.R. 1364)

- Enforcement of clinical care guidelines including APA, ASAM, SAHM, REDC LOC Criteria[16].
    - Mandate payor adoption of evidence-based clinical guidelines that are informed by clinical outcomes, not financial outcomes.

- Allow provider access to payors' internal guidelines and processes for assessing parity in application of medical necessity criteria.

- Apply the Mental Health Parity and Addiction Equity Act (MHPAEA) to Medicare, Medicaid, and TRICARE plans.

[16] https://redcconsortium.org/standards/

- Remove the 190-day lifetime limit on inpatient psychiatric hospital services
    - **Existing Legislation:** Medicare Mental Health Inpatient Equity Act (H.R. 5674/S. 3061)

III. Expanding Telehealth

The COVID-19 pandemic has drastically changed health care delivery and we commend CMS efforts and Congressional efforts in providing numerous flexibilities in service delivery to ensure individuals can still receive the health care they need during this difficult period. We estimate that 75% of our members are delivering care via telehealth in addition to providing in-person services.

It is important to note that telehealth will never replace in-person care, but it will serve as an additional tool in providing specialized, multidisciplinary treatment to those in need. For example, one of our member sites pairs Medicaid patients in-person vital sign check-up with food pantry pick up for those experiencing food and/or nutrition insecurity.

The pandemic has given us the opportunity to study the efficacy of providing eating disorders treatment via telehealth with positive results. A recent study compared eating disorder care in a telehealth (virtual) IOP setting vs. IOP in-person setting and found no differences in patient outcomes.[17] The findings included a significant decrease in eating disorders symptoms, depression, and perfectionism and a significant increase in body mass index/weight restoration.[18] 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.[19] The findings underscore what we have seen in our 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, increased participation in family-based therapy (FBT), 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.

It is important to note for our providers, telehealth delivery is not a cost-savings for our facilities. We are still seeing patients in-person at higher levels of care not deliverable via telehealth and many of the telehealth services are delivered from facilities that also treat patients in-person. Further, some member sites have seen their liability insurance premiums increase as much as 30% as they transitioned to telehealth delivery (B. Farrington, personal communication, February

[17] 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.
[18] Ibid.
[19] 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

2021). Without establishing payment parity, the continued use of telehealth as a delivery option for our patients will decline.

Further, we remain increasingly concerned that payors will end telehealth coverage and remove access to medically necessary treatment for individuals by covering in-person care only or create plan designs that limit telehealth use to specific levels of treatment (i.e., outpatient only). Such coverage restrictions will result in the discontinuation of care for patients who are actively receiving a higher level of care and prevent patients at higher levels of treatment from transitioning to the clinically essential ambulatory levels of care. For example, we have learned that BlueCross BlueShield of Illinois will no longer accept telehealth claims as of January 1, 2022 even though the PHE does not expire until January 18, 2022. Throughout the pandemic, payors have continually made decisions that present no clinical or public health reasoning for plan designs and with little advance notice to providers. These arbitrary decisions continue to be harmful for our patients with commercial insurance. Without the establishment of a foundation of telehealth coverage for mental and behavioral health plans within the commercial market, payors will continue to provide suboptimal coverage.

Recommendations

- Establish payment parity between telehealth services and in-person services.
    - Existing Washington state law: RCW 48.43.735 & Sec. 41.05.700.

- Mandate telehealth is a valid treatment modality for the delivery of essential health benefits within commercial plans.
    - Existing Washington state law: RCW 48.43.735 and RCW 41.05.700.

- Mandate commercial telehealth coverage for ambulatory levels of care, which includes partial hospitalization programming and intensive outpatient programming.

- Allow providers to deliver care with a single prior authorization per patient.
    - Commercial payors have been requiring multiple prior authorizations for the same patient if the patient starts with in-person treatment and then switches to telehealth treatment or vice versa or patients endure treatment interruptions while a new authorization is pending when they switch from in-person to telehealth or vice versa.

IV. Conclusion

Access to quality, comprehensive, and affordable care that includes behavioral health care services 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 you for your leadership in exploring ways to improve the health care system to provide the most benefit for individuals, families and loved ones with mental illness.

We look forward to continuing to work with you on this important issue.

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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 Arizona – Mesa
Center for Discovery California – Beverly Hills
Center for Discovery California – Danville
Center for Discovery California – Del Mar
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Center for Discovery California – La Habra
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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

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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
Selah House Ohio – Cincinnati
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

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The Renfrew Center Maryland – Bethesda
The Renfrew Center Massachusetts – Boston
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The Renfrew Center New Jersey – Paramus
The Renfrew Center New York – New York
The Renfrew Center New York – White Plains
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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