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Educational Webinar Series

CMS 2025 FINAL RULE & MENTAL HEALTH PARITY RULE: REGULATORY CHANGES PROVIDERS & PLANS NEED TO KNOW

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EPSTEIN BECKER GREEN

ATTAC CONSULTING GROUP

ABOUT US

Founded in 2003, ATTAC Consulting Group is recognized as a premier national consulting and auditing firm serving insurers, managed care and provider organizations on issues related to:

- Medicare Advantage
- Medicare Part D
- Medicaid
- Duals Programs
- ACOs
- Health Exchange (ACA) products

We specialize in:

- Risk Adjustment for Medicare Advantage, ACA & Medicaid Plans
- Regulatory Compliance
- Program Development
- Provider Network Development
- Operational Excellence, Business Transformation, & Systems
- Medical & Pharmacy Management

SPEAKER INTRODUCTIONS

Jocelyn Bayliss
Provider Network Management Division Lead
ATTAC Consulting Group

Kevin Malone
Member of the Firm
Epstein Becker Green

Aaron Eaton
SVP, Corporate Strategy & Product Development
ATTAC Consulting Group

AGENDA

- **Mental Health Parity** | Significant changes may impact provider network operations and reimbursement
- **Provider Network Requirements** | Tightened network adequacy standards are intended to ensure plans provide beneficiaries with timely access to a sufficient number of providers to meet Medicare Advantage & Mental Health Parity expectations
- **Access to Care for Medicaid Beneficiaries Through State Medicaid Agencies** | Updates focus on enhancing provider network adequacy to ensure timely access to services and improve overall transparency and accountability

THE PARITY JOURNEY CONTINUES

There's been lots of recent direction about additions and subtractions to requirements, and reprieves from the draft to Final Rule…the *bottom line is keep moving forward on your parity journey*

- Development of NQTLs Review & Advice
- Self-Insured Groups Playbook
- Compliance Plan Development
- Department of Labor or State Audit Support
- Updates, Revisions & Maintenance Mode

POLLING QUESTION #1

How familiar are you with Non-Quantitative Treatment Limits (NQTLs)?

A – Very familiar

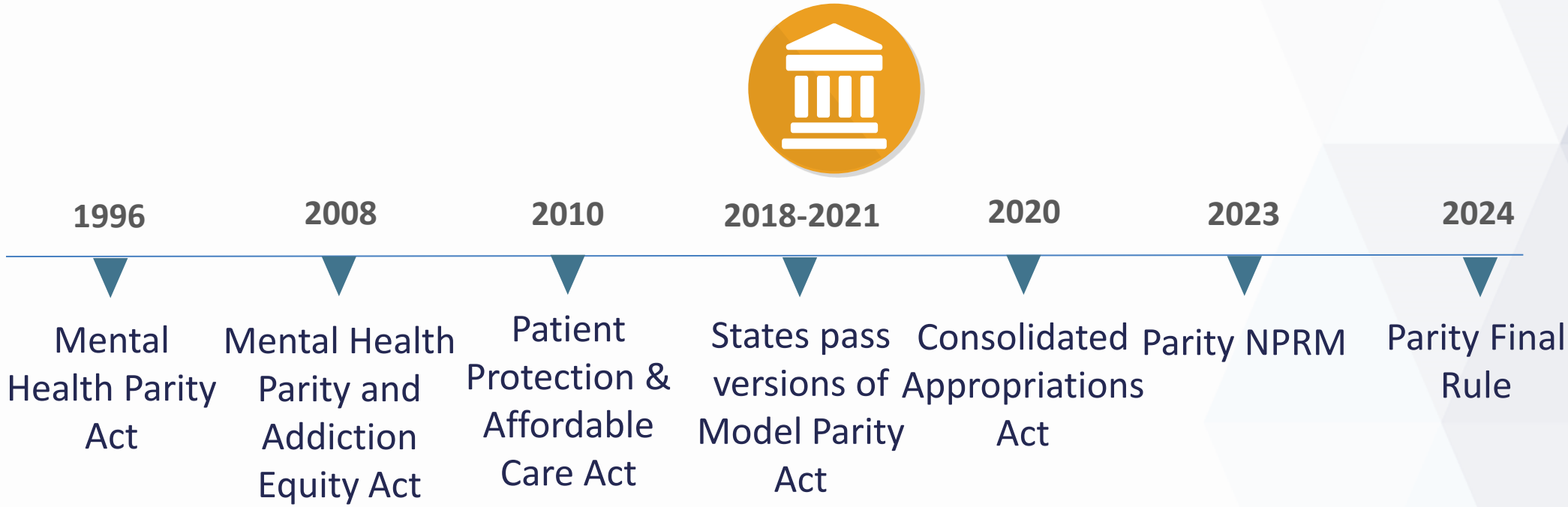
B – Reasonably familiar

C – Somewhat familiar

D – This is new to me

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

The Parity Journey



MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

- Requires covered health plans to ensure that beneficiaries have access to benefits designed and delivered in a manner that doesn't discriminate against individuals with mental health conditions or substance-use disorders
- Fundamentally a consumer-protection anti-discrimination statute, has more similarities to Civil Rights Act and Americans with Disabilities Act than most forms of managed care and insurance regulations
- Implementing regulations and sub-regulatory guidance effectuate this anti-discrimination requirement through complex series of tests
- Oversight and enforcement have steadily increased since 2008 and now require comprehensive, organizational culture changes; analogous to roll-out and adoption of HIPAA

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

New Parity Regulations

- Significantly increase operational requirements for plan/issuer to demonstrate that it's not violating parity
- Require plans/issuers to ensure factors used to design and apply NQTLs don't discriminate against MH/SUD benefits
- Require plans/issuers to collect and evaluate data metrics on outcomes as part of NQTL analysis
    - Data showing a material difference in access to MH/SUD benefits relative to M/S benefits would be “strong indicator” of noncompliance
- Authorize departments to require plans/issuers to halt application of NQTLs to MH/SUD benefits if plan/issuer fails to appropriately demonstrate that NQTL analyses comply with parity standards

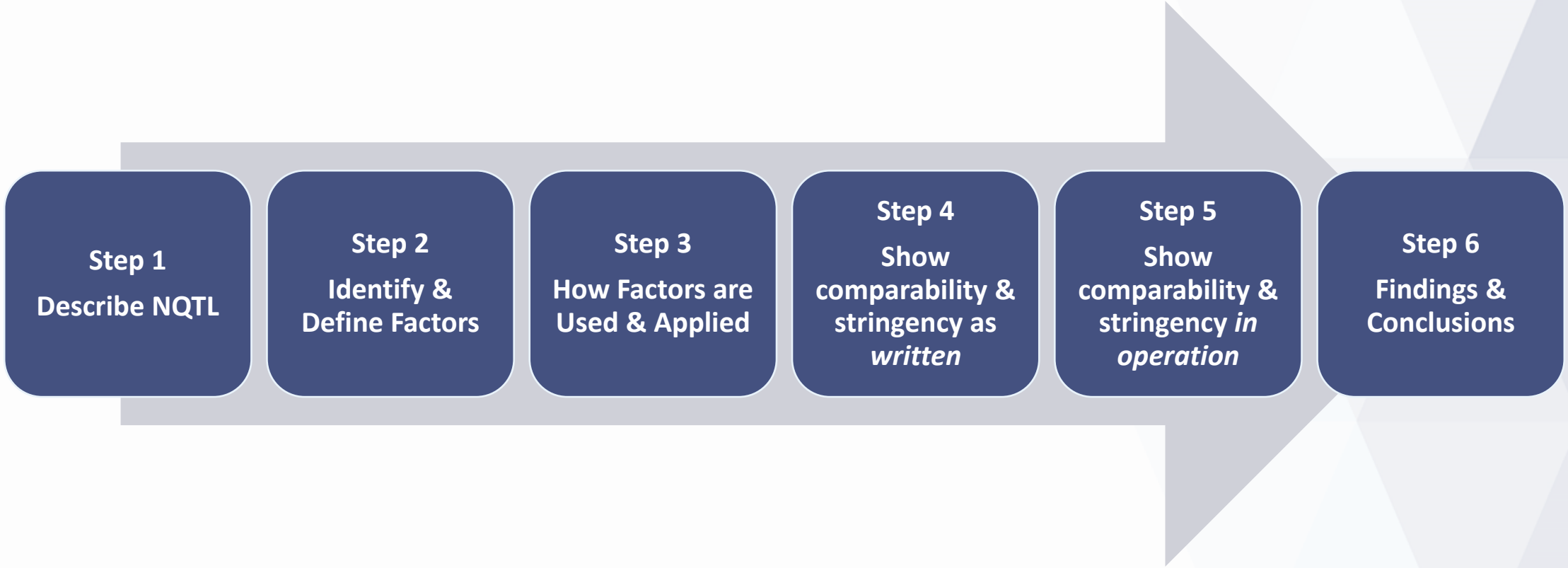
MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

Definitions & Impactful Changes

- Mental Health Benefits
  - Defined to include all covered conditions that fall under any diagnostic categories listed in mental, behavioral, and neurodevelopmental disorders chapter of current ICD or current DSM (except SUD conditions)
    - Autism spectrum disorder and eating disorders must be defined as mental health conditions
    - Plans may not use definitions for MH/SUD benefits otherwise required under state law to extent that laws exclude any condition in ICD chapter or DSM
  - Would limit plan discretion to define benefits
- More definitions will be discussed throughout this presentation including:
  - Substance-use benefits, medical or surgical benefits, factors, evidentiary standards, treatment limitation
- No definition provided for NQTL or variation of an NQTL

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

The 6-Step Comparative Analysis for NQTLs



Please reference appendix for details

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

"Relevant Data Evaluation" Requirement & Use of Operations Measures

- Plan/issuer is required to collect and evaluate relevant data metrics in designing/applying NQTL in a manner ***reasonably designed to assess impact*** of NQTL on access to MH/SUD benefits and M/S benefits
- Departments propose to require evaluation of certain data measures, including but not limited to:
  - Number and percentage of claims denials
  - In-network and out-of-network utilization rates (including data related to provider claim submissions), network adequacy metrics (including time and distance data, and data on providers accepting new patients), and provider reimbursement rates (including as compared to billed charges)
  - Any other data relevant to the NQTL required by state law or private accreditation standards
  - Allows for departments to identify additional required measures in sub-regulatory guidance

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

"Relevant Data Evaluation" Requirement & Use of Operations Measures

- **Outcomes data must be included in step 5 of plan's comparative analyses, as part of plan's demonstration of in-operation comparability of the NQTL**
  - Comparative analysis must include explanation of methodology used for data measure and provide raw or underlying data, including:
    - Sample period
    - Inputs used in any calculations
    - Detailed explanation of material differences found in data outcomes
    - Discussion of any measures implemented to mitigate any material differences
- If no relevant data exists or can be reasonably obtained to assess NQTL in operation, analysis must include a "reasoned justification" as to this conclusion and documentation of any additional safeguards/protocols used to ensure NQTL complies with all applicable requirements in absence of data

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

"Material Differences" Standard

- If data show a ***material difference*** in access to MH/SUD benefits as compared to M/S benefits, the difference is considered to be a "strong indicator" that plan/issuer violates parity
- If plan/issuer uncovers material differences in data outcomes measures, they're required to take "reasonable action" to address any material differences as necessary to ensure compliance
- Departments do not propose a definition or standard for "materiality" or "reasonable action"
  - "Material difference" is defined by a facts and circumstances assessment specific to NQTL and relevant data
  - Final rule provides examples of what departments consider "reasonable actions," including increasing reimbursement rates, adding services, reducing use of prior authorization, updating medical necessity criteria, or removing exclusions

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

Enforcement Processes

Effective date for proposed enforcement strategies and processes

- Plan years that begin on or after January 1, 2025 for definitions changes
- Policy years beginning on or after January 1, 2026 for most significant new requirements

- Inadequate documentation = substantive noncompliance; regulators have so far found that *all initial documentation submitted to date is inadequate*
- Where regulator makes a final determination of noncompliance, the plan must identify actions it will take to remedy violation
- The final rule does not assert authority for regulators to stipulate what corrective actions plan must take, or provide for regulators to require plan to take any specific action other than to cease to apply the NQTL
- Based on analysis of the totality of circumstances, the rule asserts authority for regulators to require plan to stop applying the NQTL unless and until corrective actions have been completed
- No appeal process is proposed

POLLING QUESTION #2

How familiar are you with tightened network adequacy standards around behavioral health providers?

A – Very familiar

B – Reasonably familiar

C – Somewhat familiar

D – This is new to me

NETWORK ADEQUACY CHANGES

CMS finalized regulatory changes which added several new behavioral health specialties to network adequacy requirements. Health plans are required to add these providers to their networks.

- CMS is establishing network evaluation standards for these providers

Regulatory changes include:

- Outpatient behavioral health is a new facility-specialty provider category which includes a range of behavioral health providers. CMS will include these providers in network adequacy evaluations. Outpatient behavioral health provider category includes:
  - Marriage and Family Therapists
  - Mental Health Counselors
  - Opioid Treatment Programs
  - Community Mental Health Centers
  - Additional Medicine Specialists and facilities

NETWORK ADEQUACY CHANGES

- Statutory changes established in Consolidated Appropriations Act established changes to network adequacy standards for Medicare Advantage plans. These include permitting MFTs and MCHs to enroll and start billing Medicare.
- MA plans are required to independently verify that behavioral health providers furnish services to at least 20 patients within a 12-month period utilizing reliable information. Reliable sources include:
  - MA plan claims data
  - Prescription drug claims data
  - Electronic health records
  - Similar data
- Outpatient behavioral health facility specialties will receive a 10% credit toward meeting network adequacy time and distance standards

NETWORK ADEQUACY CHANGES

Exchange Plan Network Development Requirements

- Any health plans which operate on state exchanges will be required to meet time and distance standards for provider access beginning with CY2026
- The time and distance standards will mirror the requirements for plans operating on the federal exchange
- Plans should review networks and begin to prepare to meet these new requirements

POLLING QUESTION #3

How familiar are you with CMS and state access-to-care requirement changes?

A – Very familiar

B – Reasonably familiar

C – Somewhat familiar

D – This is new to me

FUTURE OF ACCESS TO CARE REQUIREMENTS

Access to Care for Medicaid Beneficiaries Through State Medicaid Agencies

- CMS released its expectations and reporting requirements to ensure timely access to care in 2025 Final Rule
    - Effective PY 2025, CMS requires that all Medicaid and Children's Health Insurance Program (CHIP) health plans develop, conduct and enforce independent secret shopper surveys to evaluate compliance of appointment wait time standards
    - Set written standards for providers that meet or exceed those created by CMS and the state
    - Survey a statistically valid sample of primary care, OB/GYN and behavioral health providers
    - Contract with a third-party vendor to administer surveys
    - Complete annual surveys between January 1 and May 31 of each plan year
    - Report results to CMS by the second Friday of June each year

FUTURE OF ACCESS TO CARE REQUIREMENTS

Access to Care for Medicaid Beneficiaries Through State Medicaid Agencies

Many health plans have set requirements for providers based on state standards set for all primary care, specialty care, and behavioral health access and availability.

See Final Rule: Federal Register :: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality B.1.b and B.1.c

FUTURE OF ACCESS TO CARE REQUIREMENTS

Challenges to Complete Access Requirements

- **Understanding how each state agency will implement changes**
  - Will states require health plans to also survey providers?
  - When will CMS and state agencies expect changes to be implemented (2025 or 2028)?
  - Are after-hours surveys required?
- **Ensuring your provider network is meeting access requirements**
  - What % of compliance will states require going forward?
  - Where are opportunities to improve access to care?
- **Ensuring your provider contracts and training materials include latest requirements**
  - How do you ensure your provider network is aware of requirements?
  - What about providers' front-line practice staff or appointment scheduling resources?
- **Educating providers on access requirements**
  - Are you educating providers and their staff on an on-going basis?
  - What are you doing to ensure providers and their staff are compliant?

FUTURE OF ACCESS TO CARE REQUIREMENTS

Challenges to your Organization to Complete Access Requirements

- **Contracting with a third-party entity to survey your contracted providers**
  - Is your survey process design ready to support changes?
  - Are third parties providing you with meaningful and actionable information?
- **Reporting meaningful and actionable results**
  - Are you able to identify where access to care challenges are based on information you're collecting and/or receiving?
  - Are you following up on non-compliant providers and ensuring your survey volume equates to a statistically valid sample?
- **Monitoring access to care results (surveys, complaints, grievances)**
  - Are you looking at trends from access survey results, complaints and grievances?
  - Are you identifying and implementing initiatives that help improve access to care?
- **Ensuring provider directories are maintained and accurate**
  - What % of your provider data cannot be surveyed because it is incorrect?
  - Are you updating your provider data as you identify changes needed?

QUESTIONS

Please send questions via webinar control box or contact us directly

CONTACT US

Jocelyn Bayliss
Provider Network Management, Division Lead
ATTAC Consulting Group
jbayliss@attacconsulting.com

Kevin Malone
Member of the Firm
Epstein Becker Green
kmalone@ebglaw.com

Learn more about how ATTAC can help you prepare for these regulatory changes

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APPENDIX

NQTL Comparative Analysis Steps

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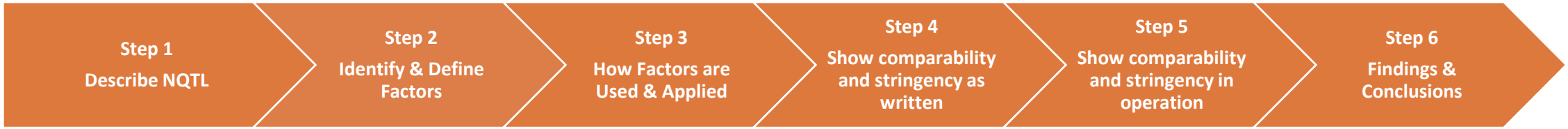
NQTL Comparative Analysis Steps



Step 1: Describe the NQTL

- Specific terms of plan, coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which NQTL appears or is described, and applicable sections of any other relevant documents (provider contracts that describe the NQTL)
- Identification of all MH/SUD and M/S benefits to which NQTL applies
- Description of which benefits are included in each benefit classification
- Identification of the predominant NQTL variation applicable to substantially all M/S benefits in each classification

NQTL Comparative Analysis Steps

Step 2: Identify & Define Factors Used to Design or Apply the NQTL

- Identification of all factors considered and evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH/SUD and M/S benefits are subject to the NQTL, to include
  - A detailed description of the factor
  - A description of each evidentiary standard (and the source)

NQTL Comparative Analysis Steps

STEP 3: Describe How Factors Are Used in Design & Application of NQTL

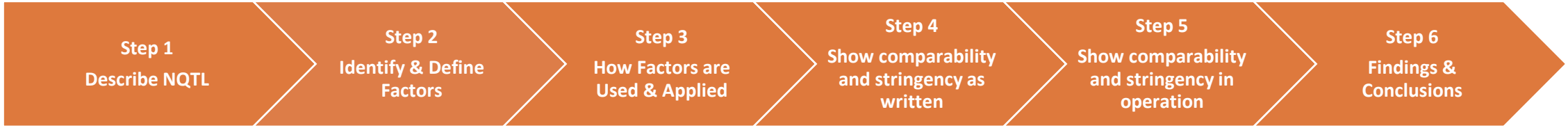
- Detailed explanation of how each factor is used to determine which MH/SUD and M/S benefits are subject to NQTL
  - If application of factor depends on specific decisions made in administration of benefits, the nature of decisions, the timing of decisions and professional designation and qualification of each decision maker
- Explanation of evidentiary standards or other information or sources considered or relied upon in designing or applying factors or relied upon in designing and applying NQTL, including in determination of whether and how MH/SUD or M/S benefits are subject to NQTL
- If more than one factor is identified, an explanation of how factors are weighted
- Any deviation(s) or variation(s) from a factor, its applicability, or its definition (including the evidentiary standards and information or sources from which each evidentiary standard was derived)

NQTL Comparative Analysis Steps

Step 4: Show Comparability and Stringency as Written

- For each factor, provide:
  - Quantitative data, calculations or other analyses showing whether MH/SUD and M/S benefits met any threshold identified in relevant evidentiary standards, and evaluation of relevant data, to determine that NQTL would or would not apply
  - Records documenting consideration/application of all factors and evidentiary standards, and results
  - Comparison of how NQTL, as written, is applied to MH/SUD and M/S benefits, including provisions of any forms, checklists, procedures, or other documentation used in designing and applying the NQTL
  - Documentation showing how the factors are comparably applied, as written, to MH/SUD and M/S benefits in each classification, to determine which benefits are subject to the NQTL
  - Explanation of reasons for deviations/variations in application of factors used to apply the NQTL to MH/SUD versus M/S benefits, and how the plan or issuer establishes such deviations or variations

NQTL Comparative Analysis Steps



STEP 5: Demonstrate Comparability and Relative Stringency In Operation

- Comprehensive explanation of how plan/issuer ensures that, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH/SUD benefits are comparable to, and applied no more stringently than for M/S benefits, including:
  - Explanation of any methodology and underlying data used; and
  - The sample period, inputs used, definitions of terms used, and any criteria used to select the benefits to which the NQTL is applied
- Identification and evaluation of data regarding the outcomes resulting from application of the NQTL to MH/SUD and M/S benefits
- Detailed explanation of “material differences” in outcomes data and basis for concluding that material differences in outcomes are not attributable to differences in comparability or relative stringency of the NQTL
- Discussion of any measures that have been or are being implemented by the plan/issuer to mitigate any material differences in access to MH/SUD benefits

NQTL Comparative Analysis Steps

STEP 6: Findings and Conclusions

- Any findings or conclusions indicating plan or coverage is not (or might not be) in compliance with parity requirements, including any planned or implemented corrective actions
- A reasoned and detailed discussion of findings and conclusions
- Citations to any additional specific information not otherwise included in comparative analysis that supports findings and conclusions
- Date of analysis and title and credentials of all relevant persons who participated in creating it
- If comparative analysis relied upon an evaluation by experts, an assessment of each expert's qualifications and extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting analysis
- For plans subject to ERISA, a certification of compliance with content requirements by one or more named fiduciaries who have reviewed analysis