Blue Cross & Blue Shield of Rhode Island (BCBSRI) Mental Health Parity and Addiction Equity Act - NQTL Comparative Analysis

The Consolidated Appropriations Act, 2021 ("CAA") requires group health plans and health insurance issuers to make available to the applicable State authority or the Secretaries of the Departments of Health and Human Services, Labor, and the Treasury (the "Secretaries"), upon request, the comparative analysis and information outlined below (the "NQTL Comparative Analysis").

The Mental Health Parity and Addiction Equity Act ("MHPAEA") Final Rules outline the elements that an NQTL Comparative Analysis must include for each NQTL. Specifically, they must include:

1. A description of the non-quantitative treatment limitation ("NQTLs");
2. Identification and definition of the factors used to design or apply the NQTL;
3. A description of how factors are used in the design and application of the NQTL;
4. A demonstration of comparability and stringency, as written;
5. A demonstration of comparability and stringency, in operation; and
6. Findings and conclusions.

BCBSRI (the "Plan")] [or Issuer Name] has completed the NQTL Comparative Analysis below, based on the content elements required under the MHPAEA Final Rules.

Overview

This analysis is a component of the NETWORK COMPOSITION STANDARDS NQTL which consists of the following NQTLs: credentialing standards, network adequacy, and in-network reimbursement rates (together, the "Network Composition Standards"). These analyses demonstrate that the processes, strategies, evidentiary standards, and other factors used to design and apply the Network Composition Standards to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the Network Composition Standards to M/S benefits.

Network Adequacy

Steps		Medical/Surgical		Mental Health/Substance Use Disorder	
		Inpatient, In-Network	**Outpatient, In-Network**	**Inpatient, In-Network**	**Outpatient, In-Network**
1	A description of the non-quantitative treatment limitation	Network Adequacy standards are not referenced in the Summary Plan Description or Certificate of Coverage, rather, they are contained and referenced in documents described below. These network adequacy standards sections apply to both M/S benefits and MH/SUD benefits, any differentiation between M/S and MH/SUD benefits is noted. All M/S and MH/SUD benefits provided in-network are subject to network adequacy standards.			
	Policies/Guidelines/Other Documents Describing Network Adequacy Standards	Network adequacy appears or is described in the following documents: • 3.02 Network Availability - Primary and Specialty Care Physicians and Behavioral Health Providers • 3.06 Monitoring and Management of Network Availability			
2	Identification and Definition of the Factors and Evidentiary Standards Used to Design or Apply Network Adequacy	Network Adequacy standards are imposed or arise from: National Committee for Quality Assurance (NCQA), Standards and Guidelines for the Accreditation of Health Plans, which requires plans to set and review access to high volume, high-cost provider categories, but does not define the standards. The Centers for Medicare and Medicaid (CMS), including the Medicare Managed Care Manual, Chapter 4, Benefits and Beneficiary Protections. State regulatory guidance: the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) requires access reviews but not criteria, and furthermore to include a separate analysis for limited network products. **Standards and data** Internal network adequacy quarterly reports and other indicators of trends including information from call-center, utilization management, and grievances and appeals departments.			

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3	Description of How the Factors are Used in the Design and Application of the NQTL	**Network Adequacy Standards** BCBSRI adopted the CMS standard that 90% of members residing within the service area fall within the established general minimum available parameters (GeoAccess) across all product lines, with reporting by type of provider as required by NCQA. These factors, definitions, and process are comparable for medical/surgical and behavioral health, and the same Committee conducts the analysis for both categories. <u>Geo Access standards</u> Primary Care Providers = two within 15 miles of the member's residence. Specialists = one within 30 miles of the member's residence. Behavioral Health (prescribers*) = two within 15 miles of the member's residence. * Psychiatrist, Clinical Nurse Specialist, and Psychiatric Nurse Practitioner Behavioral Health (non-prescribers**) = two within 15 miles of the member's residence. **Licensed Independent Clinical Social Worker (LICSW), Psychologist, Licensed Marriage & Family Therapist (LMFT), and Licensed Mental Health Counselor (LMHC). Hospital = one within 30 miles of the member's residence. Pharmacy = one within 15 miles of the member's residence. Laboratory = one within 30 miles of the member's residence. <u>Ratio standards</u> 2,500 members to one Primary Care Provider (standard applies to adult and pediatric). 10,000 members to one specialist physician. These standards were established based on industry research and in accordance with guidance from NCQA, CMS, and the Office of the Health Insurance Commissioner. A 90% compliance threshold is sourced from CMS, the categorization of provider types is sourced from NCQA with the high-volume provider specialties based on claims activity. The standards are reviewed annually. A review of the current ratios was conducted with the BCBSRI Medical Directors to validate the ratios remain appropriate. The ratios were confirmed as appropriate based on the fact that it is typically understood that all members would have a PCP (supporting the lower ratios for PCPs) whereas for BH providers and Specialists not all members would seek BH and Specialty services. Data ran by the BH Team to identify the number and percent of commercial members who had a BH claim in 2024 supported this conclusion as data reflects 59,699 members had a BH claim submitted which represents 17.7% of our total commercial membership (both self-funded and fully insured). Industry Research: BCBSRI measures high volume and high impact specialties based on NCQA guidelines. NCQA Standard NET 1 Element C Factor 1 Factor 1 provides as follows: High-volume and high-impact specialists: The organization's policies and procedures explain how it defines high-volume and high-impact specialists. The organization identifies specialties that are considered high-volume and specialties that are considered high impact. At a minimum, high-volume specialties include obstetrics/gynecology and high impact include oncology. Even if the organization only identifies the minimum specialties as high-volume and high impact, the organization must state this in its policies and procedures. If obstetricians are not appropriate for the population (i.e., Medicare), the organization may measure only gynecologists to meet the requirement. As detailed in CN 3.02 Network Availability Primary and Specialty Care Physicians and BH providers the definition of High-Volume Specialists is based on claims activity for specialties that reflect 2% of higher volume Q4 of the prior year. This is reviewed and updated on an annual basis. In addition to reviewing the claims volume we retain the core specialties of Cardiology, Allergy and Immunology, Dermatology, ENT, and Urology. We define High Impact Specialties as oncology, cardiology, orthopedics and gastroenterology. BCBSRI defines our top High Volume BH Providers based on claims volume, as well as those most likely to provide services to the largest segment of the membership. BCBSRI defines and separates high volume BH providers into two categories based upon prescriptive privileges. High Volume prescribing BH providers include psychiatrists, clinical nurse specialists, psychiatric nurse practitioners and behavioral health physician assistants. High Volume non-prescribing BH providers include licensed independent clinical social workers (LICSW), psychologists, licensed marriage & family therapists (LMFT), and licensed mental health counselors (LMHC).			
4	Demonstration of Comparability and Stringency as Written				

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		This section demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying network adequacy to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying network adequacy with respect to M/S benefits. Development and Review of Network Adequacy Standards Development and review BCBSRI maintains a Network Adequacy Governance Committee. The Committee is made up of a cross functional group from: 1. Contracting, Directors of Facility, Professional and Ancillary Contracting. 2. Behavioral Health, Managing Director of Behavioral Health 3. Legal, VP and General Counsel, Senior Program Manager 4. Grievance & Appeals (GAU), Managing Director, Claims Ops Shared Services, Director Grievance and Appeals Unit, Manager of GAU 5. Customer Service, Director of Commercial Markets, Lead Contact Center Oversight Analyst 6. Product, Managing Director Individual and Small Business Market Segments, Manager Product Management and Sales Enablement, 7. Utilization Management, Managing Director Utilization Review 8. Compliance: Director Medicare and Regulatory Compliance 9. Accreditation Director Commercial Compliance and Accreditation 10. Provider: Managing Director of Provider Services (Chair) The Committee meets quarterly. The policies reflect CMS and NCQA standards and guidance from OHIC. The Committee reviews quarterly reports that include geo access results, provider-member ratio results, and highest volume non-participating provider activity, to understand current performance. On a quarterly basis the Committee also solicits feedback from the Provider and Member Call Centers, Utilization Management and the Grievance and Appeals unit to understand if they have observed any trends related to calls, requests or complaints related to accessing participating providers. The intent is to have an 'early warning' based on trends reported by these areas of potential areas of investigation of adequacy issue. The quarterly reports provide a review of membership population and participating provider data according to NCQA categories. The Committee analyzes the data to determine geo/access by members within products, in compliance with OHIC guidance. The Committee reviews the ratio of members to providers. Non-participating provider utilization by cost and volume is also reviewed. This information on ratios, geo-access, and non-participating provider utilization is reviewed on a quarterly basis. The Committee also tracks the trend in the total dollars spent on participating/non-participating providers and claims volume on participating/non-participating providers. If a provider specialty rose above or came close to the 5% threshold designated by OHIC, then, as established within our Network Adequacy Policy, the Committee would consider if corrective action needed to be taken, such as outreach to known, non-participating practitioners. The distance standards applied to behavioral health specialties (2 practitioners within 15 miles of the member's residence) were derived internally. They have been in place for a significant amount of time and are reviewed periodically by BCBSRI medical directors for reasonableness. The distance standards for behavioral health specialties are the same as for primary care providers, and more generous than for M/S specialists (which is 1 practitioner within 30 miles). For the limited network products, the geo-access criteria is measured using the same criteria, the ratio standards are not a relevant measurement, with only 600 members the total population is below the minimum thresholds (for example: 1 provider per 2,500 members). Furthermore, the Participating Provider Administrative Manual describes the availability expectations for the various types of providers, this works to ensure accessibility to primary care providers, behavioral health providers, and specialists. The Provider Manual is made available via a secure portal, relevant parts are pasted below. The Participating Provider Administrative Manual is a long-standing document, updated annually by Provider Relations based on input from the relevant departments.			
5	Demonstration of comparability and stringency, in operation	On the most recent review, the ratios were confirmed as appropriate based on the fact that it is typically understood that all members would have a PCP (supporting the lower ratios for PCPs) whereas not all members would seek behavioral health or specialty services. BCBSRI claims data in 2024 supported this conclusion as data reflected that 59,699 members had a behavioral health claim submitted which represents only 17.7% of our total commercial membership (both self-funded and fully insured). Nonetheless, the distance standards for behavioral health specialties align with primary care provider standards. An in-operation review of 2024 data revealed that both medical/surgical and behavioral health services are available within the network access standards described herein.			

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Access by provider types met or exceeded the 90% threshold for GeoAccess. Detailed analysis within categories for various types of medical/surgical providers and behavioral health providers also met or exceeded the 90% threshold.

As of December, of 2024, for the commercial product network, the measure for medical/surgical “specialists” (examples: cardiology, urology, PT&OT, Chiro) is 1 provider within 30 miles, and the percentage of members with providers within that standard (the “access rate”) averaged 97.4%. For Primary Care, the measure is 2 within 15 miles and the access rate was 95.7%. For Behavioral Health (examples: clinical nurse specialists, marriage and family therapists, psychiatrist, psychologists, social workers), the measure is 2 within 15 miles and the access rate is 97.4% for non-prescribers and 94.9% for prescribers. While the access rate for behavioral health providers is slightly lower than for med/surg specialists, the measure is greater (2 within 15 compared to 1 within 30).

For Quarter 4, 2024, the data showed, and the Committee confirmed, all network adequacy goals for members had been achieved. While the network adequacy standards were met, the Network Adequacy Review Committee identified provider types with lower-level scores as clinical nurse specialists and BH Physician Assistants psychiatrists for behavioral health, and prosthodontists for dental. Teams within each area are working on these categories and the number of BH PAs applying for participation in the BCBSRI has increased year over year with 20 in Q4 2024 up from 7 in Q4 2023.

The non-par review is conducted in accordance with OHIC direction.

BCSRI conducts reviews for deficiencies.
For prosthodontists, Provider Relations reached out to the non-participating prosthodontists within the BCBSRI service area and found of the small number of non-participating providers, they were either no longer practicing or not interested in joining the BCBSRI network. The Network Adequacy Governance Committee reviewed these findings and determined we would continue to monitor; however, based on the recommendation from our dental team that general dentists can perform the same procedures as prosthodontists, there should still be access for all services.

The lower levels noted for BH Physician Assistants clinical nurse specialists and psychiatrists were as of Q4 2024. As of the most recent report for Q3 2024, neither are reporting at low levels, as seen in the attached document, 9/23/24 Network Adequacy Governance Committee; Commercial Fully Insured, and Direct Advance. The only category at a low level in that report was BH PAs. BH PAs participation continues to increase year over year. have only recently been admitted to the network, but BCBSRI is seeing an increasing number continue to join the network.

It is also important to note that for the general categories of BH prescribers and non-prescribers, in total, we are above the 90% threshold. BH Prescribers are categorized as: psychiatrists, nurse practitioners, clinical nurse specialist, BH physician assistant. BH Non-Prescribers are categorized as: LICSW, LMHC, LMFT, psychologists, LBA.

Ratio report, as of December 2024 for fully insured commercial membership:

Specialty	# of Members Commercial	Standards of Members per Provider	Standard of Members per Provider	Actual # of Providers	Ratio of Participating providers to number necessary
PCP All	102340	2500	40.936	1511	36.91127614
PCP Family	102340	2500	40.936	324	7.914793825
PCP IM	84807	2500	33.9228	784	23.11129977
PCP NP PA	102340	2500	40.936	511	12.48290014
PCP PEDI	17533	2500	7.0132	549	78.28095591
Allergy	102340	10000	10.234	17	1.661129568
Cardio	102340	10000	10.234	170	16.61129568

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	Dermatology	102340	10000	10.234	157	15.34102013		
	ENT	102340	10000	10.234	43	4.201680672		
	Gastro	102340	10000	10.234	95	9.282782881		
	Hemo Onc	102340	10000	10.234	101	9.869063905		
	OBGYN	102340	10000	10.234	265	25.89407856		
	Orth Surg	102340	10000	10.234	154	15.04787962		
	Urology	102340	10000	10.234	48	4.690248192		
	Imaging Centers	102340	10000	10.234	5	0.48856752		
	PT and OT	102340	10000	10.234	813	79.44107876		
	Chiropractors	102340	10000	10.234	187	18.27242525		
	Urgent Care	102340	10000	10.234	38	3.713113152		
	Optometrists	102340	10000	10.234	248	24.23294899		
	BH Non Prescribe	102340	10000	10.234	2684	262.2630448		
	BH Prescribe	102340	10000	10.234	365	35.66542896		
	BH Psychol	102340	10000	10.234	554	54.13328122		
	BH Psychiatry	102340	10000	10.234	462	45.14363885		
	BH Soc Worker	102340	10000	10.234	1204	117.6470588		
	BH CNS	102340	10000	10.234	136	13.28903654		
	BH MFT and MHC	102340	10000	10.234	926	90.48270471		
	BH NP	102340	10000	10.234	213	20.81297635		
	BH PA	102340	10000	10.234	20	1.95427008		

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	Steps	**Inpatient, In-Network**	**Outpatient, In-Network**	**Inpatient, In-Network**	**Outpatient, In-Network**
		The ratio standards analysis also supports a finding of network adequacy. The number of participating providers exceeded the number of providers necessary to satisfy the standards described above. The ratio of some types of Behavioral Health providers are among the highest of all provider types, for example 117 times the number of LICSWs indicated by the ratios and 54 times the number of Psychologists. Furthermore, for the purposes of this analysis, the network adequacy threshold would still have been met had the ratio for behavioral health providers been set at the higher 2500:1 primary care threshold rather than the specialists threshold. Providers are also available for members through telemedicine, for both medical/surgical and behavioral health services.		

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		The non-participating provider reports as of Q4 2023 measured by dollars spent and by claims show, first, that out of network utilization is low, with the percent by dollars at 060% and by claims volume at 0.50%. For both measures, the top driver is for independent labs, representing 15.6% for dollars spent and 24.4% for claims volume, for the non-par utilization. The second driver was identified as Medical Supply Company for dollars spent at 10.5% and unknown physician specialty for claim volume at 8.49%. Both secondary drivers are reviewed in a more granular detail for any trends and corrective actions. See the outcomes data in appendix below.			
6	Findings and conclusion			The above analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to apply the network adequacy standards to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to apply the network adequacy standards to M/S benefits.	

Analysis Reviewed/Approved by BCBSRI's Mental Health Parity Governance Committee (PGC)	**03/17/2025** DocuSigned by: Mary Ellen Moskal AF27958F2DBD4DA...	
Analysis Performed By:	**Mary Ellen Moskal** **Mng., Director Provider Svcs**	
I certify that this analysis was reviewed/approved by BCBSRI's Mental Health Parity Governance Committee on the above-mentioned date.	Signed by: X Sonia Worrell Asare 906280B1A3644F5... **Sonia Worrell Asare** **Managing Director, Compliance & Ethics** **Corporate Compliance Officer**	**DATE:** 3/24/2025

APPENDIX: Supporting attachments and reports

Geoaccess reports, with file names:

Commercial Network Adequacy 12_10_24

Direct Advance Network Adequacy 12_10_24

In-Network and Out-of-Network Utilization Rates
Claims Incurred January 2024 - December 2024, Processed through March 6, 2025
Commercial - Large Group Fully Funded, Large Group Self-Funded, Small Group, Individual
Commercial FEP Excluded
Inpatient and Outpatient claims only
Services rendered in Rhode Island only

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Out-of-Network Results - Outpatient		
	M/S	MH/SUD
Number of in-network claims submitted	554,394	21,181
Number of members that submitted in-network claims	153,002	6,300
Number of out-of-network claims submitted	197	889
Number of members that submitted out-of-network claims	95	60
Total claims submitted	554,591	22,070
Ratio of in-network claims to total claims	100.0%	96.0%

Out-of-Network Results - Inpatient		
	M/S	MH/SUD
Number of in-network claims submitted	11,511	1,479
Number of members that submitted in-network claims	8,853	889
Number of out-of-network claims submitted	9	6
Number of members that submitted out-of-network claims	5	3
Total claims submitted	11,520	1,485
Ratio of in-network claims to total claims	99.9%	99.6%