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.

Reimbursement Rates – including method for determining usual, customary, and reasonable charges (UCR) for out of network

		Medical/Surgical					Mental Health/Substance Use Disorder				
Steps		**Inpatient, In-Network**	**Inpatient, Out-of-Network**	**Outpatient, In-Network**	**Outpatient, Out-of-Network**	**ER**	**Inpatient, In-Network**	**Inpatient, Out-of-Network**	**Outpatient, In-Network**	**Outpatient, Out-of-Network**	**ER**
1	A description of the non-quantitative treatment limitation ("NQTLs")	Reimbursement rate standards are not referenced in the Summary Plan Description or Certificate of Coverage, rather, they are contained and referenced in documents described below. These reimbursement rate standards sections apply to both M/S benefits and MH/SUD benefits, any differentiation between M/S and MH/SUD benefits is noted. Reimbursement rates are applied for all services covered under the plan. In-network providers are paid according to a standard fee schedule or a negotiated fee schedule/rate. Non-network provider services are reimbursed using the same guidelines used to pay network providers. The payment for non-network provider services will not be more than the amount paid for network provider services. If an allowance for a specific covered healthcare service cannot be determined by reference to an existing fee schedule, reimbursement will be based upon a calculation that reasonably represents the amount paid to network providers. When covered healthcare services are received from a non-network provider, payment is either made to the subscriber or the non-network provider, less any member cost share as outlined in the members benefit plan, based on the lesser of the allowance; the non-network provider's charge; or the benefit limit; or based on federal or state law, when applicable.									
	Policies, Guidelines, and/or Other Documents	The following Departmental Policy outlines the process/guidelines regarding the review/development and implementation of any new/update fee schedules: CN_6.01 Standard Professional Fee Schedule Development and Implementation BH_2.02 Behavioral Health Facility Contracting									
2	Identification and Definition of the Factors and Evidentiary	Medicare fee schedules The Centers for Medicare and Medicaid's (CMS) Medicare Provider Fee Schedule (MFS) including the MFS for Rhode Island ("RIMFS").									

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	Standards Used to Design or Apply Reimbursement Rates	State and Federal laws and regulations State regulations and other guidance or agreements, include those issued by the Office of the Health Insurance Commissioner and Executive Orders, including Primary Care spending, hospital price growth caps, and the Cost Trends Target growth rate, (see especially 230-RICR-20-30-4, Powers and Duties of the Office of the Health Insurance Commissioner) and the federal No Surprises Act, etc. Nationally recognized payment methodologies For hospitals/facilities, national Diagnosis Related Groups (DRG), either CMS or All Patients Refined Diagnosis Related Groups (APR), Ambulatory Payment Classification (APC) and/or Outpatient Prospective Payment System (OPPS) are used when applicable/possible and the National Clinical Laboratory Fee Schedule (NCLFS) is also used. BCBSRI claim utilization data Utilization data that includes 12 months of prior actual claims history paid to providers. Industry data Industry data such as RI Medicaid payment rate data may be used for either BH or MS services for which Medicare does not cover/price, for example: Early Intervention, Doulas, Children's Intensive Services Programs, Adult Intensive Services Programs, and ABA, which do not have Medicare rates, therefore, Medicaid rates were used as reference rates. Strategy Rates reflect/are based off the Medicare Fee Schedule with consideration of the impact to premiums and the delivery system and ensuring an adequate network, and regulatory requirements. Although base MFS are used, BCBSRI determines different percentages of the base MFS to establish its standard fee schedule rates. For example, common evaluation and management and therapy codes for medical and BH/SUD and MS providers is generally at higher percentages than surgical procedures or machine tests. This is due to the fact that evaluation codes are generally the main codes billed by non-surgical MS specialists and BH/SUD providers. By establishing higher percentage rates for E&M and therapy services, BCBSRI invests in its network providers both on the MS and BH/SUD side, ensuring that the established percent of the Medicare Fee Schedule are equal to or higher for BH/SUD providers than MS providers for the same or similar E&M and therapy codes.									

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3	Description of How the Factors are Used in the Design and Application of the NQTL	**Overview of the reimbursement rates** Reimbursement rates are used to guide the development of and determine payment rates for in-network and out-of-network providers for services covered by the plan. **How the reimbursement policies were developed** Reimbursement rates and budgets are developed by/in collaboration with the Chief Financial Officer, Chief Medical Officer, Senior Vice-President for Network Management, the Director of Behavioral Health, and/or other contracting professionals. **Name of Group: Standard Professional Provider Fee Schedule Development Workgroup**									

Member	**Title**	**Qualifications**
Jeff Boehnke	Director Network Management, Hospital and Physician Contracting	SME
Mark Bevelander	Director Network Management, Physician and Ancillary Contracting	SME
Mark Fusco	Senior Contract Manager, Hospital and Physician Contracting	SME
Shane Ivens	Manager Analytics, Enterprise Analytics	SME
Jill Rivard	Senior Health Data Analyst, Enterprise Analytics	SME
James Reed	Health Data Analyst, Enterprise Analytics	SME
Derah Amado-Yattaw	Health Data Analyst, Enterprise Analytics	SME
Jennifer Tavares	Sr Reimbursement Analyst, Lifecycle	Certified Professional Coder/SME
Rosaly Cuevas	Manager Behavioral Health Quality, Network & Policy, Delivery System Innovation	SME/MPA

BCBSRI generally uses RIMFS from the prior year to develop its standard fee schedule as well as its negotiated fee schedule(s). Workgroups consisting of staff from Network Management, Data and Analytics, and Behavioral Health review the Rhode Island Medicare Fee Schedule (RIMFS) and the National Medicare Fee Schedule (NMFS), 12 months of prior utilization data, pricing models, and spending forecast data when updating fee schedules. In creating/updating a fee schedule, the workgroups may vary the percent of the RIMFS or the national MFS to moderate the impact to providers from CMS's changes to the rates/dollar amounts in the RIMFS, in consideration of regulatory compliance obligations, the impact to providers (considering the cumulative impact of rate changes), and/or investment areas.

After review and development of a draft fee schedule, the workgroups deliver summary presentations to senior leadership.

For in-network providers:

For professional providers; BCBSRI contracts with each individual practitioner directly and sets its Standard Fee Schedule which applies to non-negotiated providers. The Standard Fee Schedule is reviewed annually and generally updated on an annual basis.

As a business rule, BCBSRI applies the concept of "lower of" reimbursement payments which operationally reimburses providers the lower of their charge or the allowable amount. This is in place for all professional provider types. Consideration is also given to state laws and regulations and other guidance or agreements.

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		For facilities; (e.g., inpatient/outpatient non-professional providers), BCBSRI contracts with in-network facility providers on an individual contract basis for which each facility's rates are negotiated using industry standard reimbursement methodologies e.g., such as Medicare/CMS and/or APR DRG and APC outpatient payment rates when available. When not available or when a facility will not agree to such industry standard reimbursement methodology, BCBSRI uses per diem or per service rates which are generally based on other rates BCBSRI has established for the same or similar services in the market, as well as any specialty services that the provider provides, or applies CPI-type increases to previously established rates. Consideration is also given to state laws and regulations and other guidance or agreements. ***For out-of-network providers:*** **For outpatient professional services;** payment rates are set at BCBSRI's Standard Fee Schedule. As a business rule, BCBSRI applies the concept of "lower of" reimbursement payments which operationally reimburses providers the lower of their charge or the allowable amount. This is in place for all professional provider types. **For out-of-network facilities;** a fee schedule (i.e., reimbursement or payment rates) is developed based on 12 months of prior actual claims history paid to in-network providers; this utilization/data model is then used to determine weighted average rates to create the out-of-network fee schedule for facilities. **Reviews and updates:** Reimbursement rates are reviewed annually, and both the MS and BH/SUD fee schedules are evaluated and updated during the same timeframe to ensure there is consistency and parity related to any changes. The Medicare Fee Schedule in effect as of the initiation of the evaluation is used (for example, a review starting in May uses the fee schedule in effect at that time). This ensures consistency and certainty in the base fee schedule used. The fee schedule is then implemented in the Fall of each year. For out-of-network facility providers, the fee schedule is updated in April, for both BH/SUD and MS services as it uses the most recent updated fee schedule from the prior Fall. This timing allows for updated rates being based off/take into consideration any January 1 rate updates for new codes; and allow for consideration of participating facility provider rates that generally occur on January 1 of each year to be used in the updated fee schedule in April. The processes are conducted by the workgroups described above.									
4	Demonstration of Comparability and Stringency as Written	**Application to Behavioral Health policies and Medical/Surgical policies:** The reimbursement rate setting process for professional providers occurs within the areas responsible for the services and with expertise and knowledge of the delivery system for each category of care. The two (2) workgroups apply the same/significantly similar considerations. The workgroups that develop the Behavioral Health and Medical/Surgical Fee Schedules coordinate with each other during the process and communicate to senior managers the processes and considerations used to develop fee schedules and the final recommendations. Collaboration between Senior Leaders ensures alignment to business goals and priorities. For hospital contracts, there is one negotiation group that works in collaboration with the hospital/hospital group to determine acceptable payment rates, within the regulatory limit, for both M/S and BH services rendered by the hospital/hospital group. Non-hospital facility negotiations are conducted by each operational area, using comparable annual budgets to inform the negotiated payment rates.									
5	A demonstration of comparability and stringency, in operation	**Outcomes Data:** The specific payment levels as a percentage of the RIMFS, and on a dollar level, that are paid to Behavioral Health and Medical/Surgical providers with comparable levels of training (MDs, PhDs, master's level), are comparable. Psychiatrists are paid comparable amounts to Medical/Surgical physicians; psychologists are typically paid a higher percentage of RIMFS than Medical/Surgical chiropractors; and master's level Behavioral Health clinicians (i.e., LICSWs) are paid more than comparably trained Medical/Surgical clinicians (i.e., Occupational Therapists and Physical Therapists). This is evidence that in operation BCBSRI's reimbursement methodologies meet MHPAEA's NQTL standards. Additionally, BH reimbursements have been increased to encourage providers to increase access for psychiatric diagnostic evaluations services for children and adolescents (90791-TU and 90792-TU, see below). *Please contact your account manager for "Payment level comparison."*									

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	Findings and Conclusions	This analysis has demonstrated that the processes, strategies, evidentiary standards, and other factors used to develop in- and out-of-network rates for Behavioral Health 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 develop in- and out-of-network rates for Medical Surgical benefits.									

Analysis Reviewed/Approved by BCBSRI's Mental Health Parity Governance Committee (PGC)

Analysis Performed By:

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I certify that this analysis was reviewed/approved by BCBSRI's Mental Health Parity Governance Committee on the above-mentioned date.

X Signed by: Sonia Worrell Asare 096289B1A3644E5...
Sonia Worrell Asare
Managing Director, Compliance & Ethics
Corporate Compliance Officer

DATE: 3/24/2025