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

		Medical/Surgical		Mental Health/Substance Use Disorder	
Steps		**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: • CN 3.02 Network Availability - Primary and Specialty Care Physicians and Behavioral Health Providers (submitted to Compliance on 10/30/25 for signature and publication in Archer). • CN 3.06 Monitoring and Management of Network Availability (published on 7/2/2025) • OHIC Network Adequacy Template			
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 for Small Group and Direct Pay based on the Federal Standard which measure time/distance by county for defined provider specialties including primary care, specialist care and behavioral health. **Standards and data**			

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		Internal network adequacy quarterly reports and other indicators of trends including information from call-center, utilization management, and grievances and appeals departments.			
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 OHIC, CMS and NCQA. These factors, definitions, and process are comparable for medical/surgical and behavioral health, and the same Committee conducts the analysis for both categories. Geo Access standards: access is defined by county within the BCBSRI Service Area: Providence County: defined as Large Metro Bristol County: defined as Metro Kent County: defined as Metro Newport County: defined as Metro Washington County: defined as Metro Ratio standards 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 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 CMS and OHIC with NCQA measured categories defined as high volume specialist of OB-GYN, high impact specialist of Oncology, Primary Care defined as Family Medicine, Internal Medicine, Pediatricians and per the RI State Mandate allowing Nurse Practitioners (NPs) and Physician Assistants (PAs) to be designated as PCPs. Behavioral Health providers are defined per NCQA as high volume prescribing practitioners to include psychiatrists, clinical nurse specialists, psychiatric nurse practitioners and behavioral health PAs. High volume non prescribing practitioners to include independent licensed clinical social workers (LICSWs), psychologists, licensed marriage & family therapists (LMFTs) and licensed mental health counselors (LMHCs). 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. In addition to the Federal/OHIC standard, 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 provider specialties, (including primary care and behavioral health) is based on the federal/OHIC standard as well as more specific definitions defined by NCQA as a minimum requirement. . This is reviewed and updated on an annual basis. The federal/OHIC template currently defines the provider categories to be monitored as follows: **Individual Provider Specialty Type:** Allergy and Immunology			

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Steps		**Inpatient, In-Network**	**Outpatient, In-Network**	**Inpatient, In-Network**	**Outpatient, In-Network**
		Cardiology Cardiothoracic Surgery Chiropractor Dental Dermatology Emergency Medicine Endocrinology ENT/Otolaryngology Gastroenterology General Surgery Gynecology, OB-GYN Infectious Disease Nephrology Neurology Neurosurgery Occupational Therapy Oncology - Medical, Surgical 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		

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Steps		**Inpatient, In-Network**	**Outpatient, In-Network**	**Inpatient, In-Network**	**Outpatient, In-Network**
		Facility Specialty Types: Acute Inpatient Hospitals (must have Emergency services available 24/7) Cardiac Catheterization Services Cardiac Surgery Program Critical Care Services – Intensive care Units (ICUs) Diagnostic Radiology (Free-standing; hospital outpatient; ambulatory health facilities with Diagnostic Radiology) Inpatient or Residential Behavioral Health Facility Services Mammography Outpatient Infusion/Chemotherapy Skilled Nursing Facilities Surgical Services (outpatient or ASC) Urgent Care			
4	Demonstration of Comparability and Stringency as Written	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), Manager of GAU 5. Customer Service, Director of Commercial Markets, Lead Contact Center Oversight Analyst 6. Product, Manager Product Mgmt & Sales Enablement 7. Utilization Management, Managing Director Utilization Review 8. Compliance: Director Medicare and Regulatory Compliance; Corporate Affairs, Corporate Compliance & Ethics 9. Accreditation Director Commercial Compliance and Accreditation 10. Provider: Managing Director of Provider Services (Chair) The Committee meets quarterly. The policies reflect CMS, OHIC and NCQA standards. 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			

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		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 or access issues. The quarterly reports provide a review of membership population and participating provider data according to CMS, OHIC and 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 primary care, medical specialists and behavioral health specialties are measured as defined by the federal standard based on county designation and by defined provider/facility specialty. For the limited network products, the geo-access criteria is measured using the same criteria, the ratio standards are not a relevant measurement, as 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 2025 data for Q1 – Q3 revealed that majority of medical/surgical and behavioral health services are available within the network access standards described herein. The following counties were identified with results below 90% in the most recent review conducted in Q3 2025: Q1: For Commercial Fully Funded: Providence County: OB-GYN was 88.3%. For Commercial Self Funded: Providence County: OB-GYN was 88.9% For Direct Advance: Newport County: Outpatient Infusion/Chemotherapy was 58.1% Washington County: Allergy and Immunology was 69.7%, Emergency Medicine was 81.8%, Endocrinology was 77.8%, Gastroenterology was 78.8%, General Surgery was 62.6%, OB/GYN was 42.4%, Nephrology was 69.7%, Ophthalmology was 52.5%, Pulmonology was 83.8%, Speech Therapy was 52.5%, Urology was 83.8%, Cardiac Catheterization Services was 69.7%, Cardiac Surgery Program was 69.7%, Critical Care Services (ICU) was 82.8%, Mammography was 82.8%, Outpatient Infusion/Chemotherapy was 48.5%, Surgical Services (outpatient) was 82.8%. Providence County: Emergency Medicine was 85.3%, Endocrinology was 89.8%, OB/GYN was 72.0%, Ophthalmology was 82.9%, Outpatient Clinic Behavioral Health was 88.8%, Speech Therapy was 66.1%, Cardiac Catheterization Services was 88.1%, Cardiac Surgery Program was 88.8%, Critical Care Services (ICU) was 82.2%, Inpatient or Residential BH Facility Services was 89.0%, Mammography was 82.2%, Outpatient Infusion/Chemotherapy was 82.2%, Surgical Services (outpatient) was 85.5%. For DSNP: Providence County Surgical Services (outpatient) was 88.5% For Medicare Advantage: Providence County: OB/GYN was 89.4%, Surgical Services (outpatient) was 84.4%. The Network Management Team is addressing the areas that fell below goal by reviewing the categorization of providers to make sure all facility specialties have all applicable facilities captured. In addition BCBSRI allows for Telemedicine:			

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		Telemedicine/Telephone services (as outlined Payment Policy Telemedicine/Telephonic Services for Commercial products and Medicare Advantage Plans) are allowed for the following provider types: • Adult Intensive Services (AIS) • Applied Behavior Analysis (ABA) • Child and Family Intensive Services (CFIT) • Clinical nurse specialist • Clinical social worker • Emergency Medicine -Telemedicine services only • Hospital Clinic visits • Intensive Outpatient Program (IOP) • International Board-Certified Lactation Consultant (RLC) • Licensed Behavior Analyst • Licensed Marriage and Family Therapist • Licensed Mental Health Counselor • Nurse Midwife • Nurse practitioner • Nurse practitioner Behavioral Health (NP-BH) • Partial Hospitalization (PHP) • Physical/Occupational/Speech Therapist - Telemedicine services only • Physician assistant • Physician assistant Behavioral Health (PA-BH) • Physicians • Psychiatrist • Psychologist • Registered dietician • Urgent Care – Telemedicine services only which increases access outside the geo access parameters outlined. <u>Appendix A: Ratio report, by county, as of September 2024 for fully insured commercial membership:</u> 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. Providers are also available for members through telemedicine, for both medical/surgical and behavioral health services. The non-participating provider reports as of Q2 2025 measured by dollars spent and by claims show, first, that out of network utilization is low, with the percent by dollars at 0.52% and by claims volume at 0.43%. For both measures, the top driver is for independent labs, representing 22.88% for dollars spent and 27.04% for claims volume, for the non-par utilization. The second driver was identified as Medical Supply Company for dollars spent at 8.74% and 8.47% for claims volume. Both secondary drivers are reviewed in a more granular detail for any trends, corrective actions and outreach by Provider Relations for providers within the BCBSRI service area to determine if the providers are interested in joining the BCBSRI participating network. 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)	**11/6/2025**	**Implementation Date: 1/1/2026**
Analysis Performed By:	DocuSigned by: Mary Ellen Moskal AF27958F2DBD4DA... **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.	**X** Signed by: Sonia Worrell Asare 096289B1A3644F5... **Sonia Worrell Asare** **Managing Director, Compliance & Ethics** **Corporate Compliance Officer**	**DATE: 11/6/2025**

<u>APPENDIX: Supporting attachments and reports</u>

Geoaccess reports, with file names:

Commercial Network Adequacy 12_10_24

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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

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%