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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").

Blue Cross & Blue Shield of Rhode Island (BCBSRI) has completed the NQTL Comparative Analysis below, based on guidance released by the Departments of Labor, Health and Human Services, and Treasury.

Medical Management NQTL (Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative)

		Medical/Surgical					Mental Health/Substance Use Disorder				
Step		**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	Medical management (or utilization management, or UM) criteria are benchmarks against which the medical necessity of services proposed or performed are evaluated. **BCBSRI does not review Behavioral Health Services for medical necessity or medical appropriateness in any classification.** BCBSRI assesses whether services are investigational or experimental. Experimental or investigational services include any medical or behavioral health treatment, procedure, facility, equipment, drug, device, supply, or service (herein collectively referred to as *"the service"*) when the service has progressed to limited human application but has not been recognized as proven effective in clinical medicine. <u>Specific Subscriber Agreement terms</u>: Exclusions: Experimental or Investigational Services: Treatments, procedures, facilities, equipment, drugs, devices, supplies, or services that are experimental or investigational except as described in Section 3. Section 3 includes the following: *Clinical Trials* This plan covers clinical trials as required under R.I. General Law § 27-20-60. An approved clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is being performed to prevent, detect or treat cancer or a life-threatening disease or condition. In order to qualify, the clinical trial must be: federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or a drug trial that is exempt from having such an investigational new drug application. To qualify to participate in a clinical trial: you must be determined to be eligible, according to the trial protocol; a network provider must have concluded that your participation would be appropriate; and medical and scientific information must have been provided establishing that your participation in the clinical trial would be appropriate. If a network provider is participating in a clinical trial, and the trial is being conducted in the state in which you reside, you may be required to participate in the trial through the network provider. Coverage under this plan includes routine patient costs for covered healthcare services furnished in connection with participation in a clinical trial. The amount you pay is based on the type of service you receive. Coverage for clinical trials does not include: the investigational item, device, or service itself; items or services provided solely to satisfy data collection and that are not used in the direct clinical management; or a service that is clearly inconsistent with widely accepted standards of care. *Off-label Prescription Drugs* This plan covers off label prescription drugs for cancer or disabling or life-threatening chronic disease if the prescription drug is recognized as a treatment for cancer or disabling or life-threatening chronic disease in accepted medical literature, in accordance with R.I. General Law § 27-55-1.								
1.b.	Policies, Guidelines, and/or Other Documents Describing the NQTL	CN 5.01 Medical and Payment Policy Development and Implementation Medical and Payment Policy Review Committee Charter 2024									

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		Blue Cross and Blue Shield Association Guidelines (Chapter 4, Chapter 5) Medical Technology Assessment Committee (MTAC) Charter 2024 CI 1.01 UM Criteria and References CI 03.03.12 Investigational Experimental Treatment Utilization Management Committee Charter 2025									
2	What factor(s) were used to determine that the NQTL will apply to MH/SUD benefits and M/S benefits described above? How is each factor defined?	BCBSRI reviews services that may be investigational or experimental, or that there may be limited evidence for the service. Findings in investigational or experimental cases are based on factors including evidence-based evaluations by consensus panels and technology evaluation bodies, national medical professional organizations, and governmental agencies, as well as state law. The sources include: Blue Cross Blue Shield Association (BCBSA) coverage guidelines, which provides access to nationally respected evidence-based assessments of medical technologies, peer-reviewed journals and websites of specialty boards. It includes: • Food and Drug Administration (FDA) (some medications are covered under the medical policy). For drugs, devices, or supplies, additional resources include American Hospital Formulary Service Drug Information, United States Pharmacopoeia Dispensing Information and American Medical Association (AMA) Drug Evaluations (USP/NF). • Centers for Disease Control (CDC) for vaccines. Centers for Medicare & Medicaid Services (CMS) (For Medicare Advantage members, BCBSRI always defers to the Medicare coverage criteria, in the form of a National Coverage Determination (NCD) or Local Coverage Determination (LCD) from the applicable contractor for our region). Policy Reporter (a web-based tool used to track and store policies from insurers) (to inform and validate industry-wide policy coverage standards but not as a primary determinant). Rhode Island General Law and Regulatory directions, including the use of American Society of Addiction Medicine (ASAM) for behavioral health pursuant to state law requirements. BCBSRI also utilizes InterQual Criteria to determine medical necessity (for prior authorization criteria – noting this is not applied to Behavioral Health services). Limited Evidence (for Interqual-sourced criterial) is based on one or more of the following: • Research to date has not demonstrated this intervention's equivalence or superiority to the current standard of care; • The balance of benefits and harms does not clearly favor this intervention; • The clinical utility of this intervention has not been clearly established; • The evidence is mixed, unclear, or of low quality; • The intervention is not a standard of care.									
3	Description of How the Factors are Used in the Design and Application of the NQTL	The Payment and Medical Policy Review Committee is the review and approval body for all presented BCBSRI policies. (Medical Policies are those that support medical necessity coverage determinations and provide guidelines for determining what medical/behavioral health services, procedures, devices and drugs may be eligible for coverage). The Committee is composed of representatives from the departments identified below, with others added as needed: 1. Utilization Management 2. Medical Director									

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		3. Behavioral Health 4. Provider Relations 5. Contracting/Network Management 6. Grievances and Appeals Unit 7. Government Programs 8. Product Marketing 9. Special Investigation Unit 10. Audit and Recovery/Payment Integrity 11. Pricing and Trend Support 12. Legal 13. Customer & Provider Service 14. HCL Claims (as required) 15. Policy Department 16. Payment Controls 17. Other departments as needed The decision-making process to develop a policy is outlined below and can be found in more detail in internal policy CN 5.01, Medical and Payment Policy Development and Implementation: 1. Policy Initiation Phase a. A policy request is made by an internal or external (i.e. provider) stakeholder. Requests may be initiated for a number of reasons, including but not limited to request for new service, identified lack of clarity in existing policy, changes in benefits, new literature to support modifying criteria, etc. b. Policy request is assigned to an analyst, who reviews request with a Medical Director 2. Policy Research and Development Phase a. Research is conducted using a variety of resources including: i. BCBSA Evidence Positioning System ii. Centers for Medicare & Medicaid Services iii. Food and Drug Administration iv. Centers for Disease Control v. Policy Reporter/other industry standards/information vi. Professional Society Position Statements vii. Local Participating providers with expertise in the area of policy topic b. Decision Making Process—the following decision processes are used in making determinations: i. Decisions about experimental or investigational services ii. Medically Necessary Care iii. Prior Authorization (noting Utilization Management, including Prior Authorization, is not conducted on Behavioral Health services) iv. Policy determinations made based on benefits, coverage, and medical necessity guidelines c. Policy Development Document is utilized to document the policy development process. Information that is captured as part of this process includes: i. Status of current policy ii. Scope of proposed policy 1. Policy classification 2. UM systems/edits that should be implemented (noting Utilization Management is not conducted on Behavioral Health services) 3. Benefit changes 4. Products policy applies to									

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		iii. Financial impact iv. Coverage guidelines as well as industry information (includes Medicare NCD/LCD) v. Provider Comments vi. System implementation edits d. Annual and new policy review 3. Policy Final Review and Decision Phase a. Payment and Medical Policy Review Committee—policy is brought to committee for review/approval 4. Implementation Phase a. During the implementation phase, the systems configuration is completed to properly adjudicate the policy updates in the claims payment system b. This phase also allows for a 60-day notification period to providers of the policy change 5. Finalization of Policy—upon completion of all elements above, policy is considered final <u>Process description details</u> BCBSRI's Medical Policy receives a request for policy. Research is conducted on a case-by-case basis. Medical Policy analyst will check CMS and BCBSA to see if a policy already exists and if it states whether the service is experimental/investigative. • If it does identify the service to be experimental/investigative, then the above process applies for the development/renewal of the policy deeming the service not medically necessary for the reason of it being experimental/investigative. • If it does not identify the service to be experimental/investigative, market research is completed to review other sources regarding coverage (using Policy Reporter). Prior to Medical and Payment Policy Review Committee, a review is conducted with a Medical Director to determine if a code will require prior authorization or be covered without requiring authorization. For Behavioral health services, services are covered without the application of prior authorization. The Payment and Medical Policy Review Committee makes a final review and approval regarding plan administration of the proposed and/or revised policy. In addition, services may be brought to BCBSRI Medical Technology Assessment Committee (MTAC) for review. BCBSRIs' Medical Technology Assessment Committee (MTAC) is a multi-disciplinary group within Clinical integration. Composition will include external subject matter specialists; Policy, Utilization Management; and the Chief Medical Officer. The MTAC is chaired by a BCBSRIs' Medical Director. MTAC reports to UM Committee. Medical technology is constantly evolving, and medical policies are subject to review and periodic update. A component of MTAC is the evaluation of emerging and new uses of existing technologies and medical interventions, to determine if they warrant inclusion in BCBSRI's medical policies. Following the technology assessment, BCBSRI's Payment and Medical Policy Review Committee may develop clinical coverage criteria and a supporting medical policy. The technology evaluation is based upon a review of clinical information gathered from various sources including: • Independent health technology assessment organizations; providing assessment of the safety and efficacy of technologies. • Evidence-based guidelines of regulatory/government bodies • Clinical outcome studies published in peer-reviewed scientific/medical literature. • National Payer policies and guidelines • Evidence Positioning Systems (BCBSA) The implementation phase of a medical policy is initiated upon receipt of final review and approval by the members of the Committee.									
4	Demonstration of Comparability and Stringency as Written	The Payment and Medical Policy Review Committee and Medical Policy department evaluates and makes recommendations regarding plan administration of proposed and/or revised policies for both M/S and MH/SUD.									

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		The Committee's bi-weekly meetings (24 times annually) provide an open forum for the presentation of newly proposed and/or revised policies as well as annual reviews of policies with no updates to all affected departments. The Committee drafts new medical policies at any of these meetings. Reviews of existing policies, in accordance with the health care accreditation body "National Committee for Quality Assurance" (NCQA) standards, are conducted at least annually for each medical policy, and payment policies are reviewed once every three years. The policy development process applies equally to both M/S and MH/SUD services. The Committee is comprised of experts in M/S and MH/SUD benefits, policy and coding and includes several members who are Certified Coders. The Committee meets regularly to review any new developments or emerging evidence. The Committee relies on evidence-based guidelines. The Committee uses the same process to determine whether to include or exclude a service or impose other rules. The resulting correct coding operational implementation review and configuration process includes the following teams/departments: Provider Payment Integrity, Medical Policy, Provider Relations, Contracting, Claims, and Behavioral Health. An inventory of all medical and payment policies and underlying sources is maintained, showing the category of policy (medical or payment) or if coverage is the result of a mandate, and an indicator of the reference source for the coverage determination. Note, because of the high number of medical and payment policies related to medical/surgical services, there is not a separate list of all policies that include an exclusion.									
5	A demonstration of comparability and stringency, in operation	Medical and payment policies for MH/SUD services are developed in the same manner, and approved by the same governing body, as policies for M/S. In 2024, BCBSRI expanded coverage for biomarker testing including for behavioral health conditions, in part pursuant to a state mandate. **BCBSRI does not review Behavioral Health Services for medical necessity or medical appropriateness in any classification.** A review of applications from January 2024 –December 2024, found there had been no denials of a member's request for an experimental/investigative for behavioral health services. A UM validation report is run daily to validate no UM denials are issued related to behavioral health services with reason of experimental/investigative. If a request is determined to be denied in error, a correction would be completed, and staff would be educated.									
6	Findings and conclusion	This analysis has demonstrated that the processes, strategies, evidentiary standards, and other factors used to develop medical necessity standards for 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 develop medical necessity standards for M/S benefits.									

Analysis Reviewed/Approved by BCBSRI's Mental Health Parity Governance Committee (PGC)	**02/27/2025**

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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 096289B1A3644F5... **Sonia Worrell Asare** **Managing Director, Compliance & Ethics** **Corporate Compliance Officer**	**DATE:** 3/13/2025