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.

Standard for Providing Access to Out of Network Providers

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply standards for providing access to out of network providers, for mental health or substance use disorder ("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 design and apply those standards for medical surgical ("M/S") benefits.

		Medical/Surgical		Mental Health/Substance Use Disorder	
Steps		Inpatient, Out-of-Network	Outpatient, Out-of-Network	Inpatient, Out-of-Network	Outpatient, Out-of-Network
1	A description of the non-quantitative treatment limitation	Emergent Inpatient services do not require review. (Providers submit Notification of admission) An Out of Network review applies if the product does not carry an out of network benefit, or if the member requests application of in-network benefits to out-of-network services, for: Elective Inpatient Surgeries, Acute Inpatient Rehabilitation Facility Services, Skilled Nursing Facility Services, and Long Term Acute Care (LTAC). <u>Specific plan or coverage terms</u>: Network Authorization For services that cannot be provided by a *network provider*, you can request a *network authorization* to seek services from a *non-network provider*. With an approved *network authorization*, the *network benefit* level will apply to the authorized *covered healthcare service*. If we approve a *network authorization* for you to receive services from a *nonnetwork provider*, our reimbursement will be based on the lesser of our *allowance*, the *non-network provider's charge*, or the *benefit limit.* For more information, please see the	An Out of Network review applies if the product does not carry an out of network benefit, or if the member requests application of in-network benefits to out-of-network services. <u>Specific plan or coverage terms:</u> same	Emergent Inpatient services do not require review. (Notification of admission) An Out of Network review is not required.	An Out of Network review is not required.

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		How *Non-Network Providers* Are Paid section.			
	Policies/Guidelines/Other Documents Describing Access to out of network providers	Relevant references appear or are described in the following documents: CN 5.01 Medical and Payment Policy Development and Implementation Medical and Payment Policy Review Committee Charter 2025 Blue Cross and Blue Shield Association Guidelines (Chapter 4, Chapter 5) CI 3.06: Out of Network Services (Non-Medicare Plans) Medical Technology Assessment Committee (MTAC) Charter 2025 CI 1.01 UM Criteria and References Payment Policy: Behavioral Health Services Inpatient and Intermediate Levels of Care NCQA Standards and Guidelines for the Accreditation of Health Plans-UM1			
2	Identification and Definition of the Factors and Evidentiary Standards Used to Design or Apply the NQTL	NCQA Standards and Guidelines for the Accreditation of Health Plans (applies to Commercial Products only) • Requests for coverage of out-of-network services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of services closer or sooner than provided or allowed by the organization's access or availability standards). **NOTE: Medical Necessity review is not applied for behavioral health services**. (UM1A, NCQA Standard) BCBSRI Medical Coverage Policy: Out-of-Network Services Requests (applies to Commercial Products only) The review process and criteria when a member, or a provider on behalf of a member, is requesting services from a non-contracted/out-of-network provider and is requesting that the services be considered at the member's in-network benefit level. Covered services from non-contracted/out-of-network healthcare providers are medically necessary and would be considered at the member's in-network benefit level when one of the following criteria is met: A. Services that are determined to be urgent or emergent. • Emergency care services means inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services. Urgent Care Services are defined as services furnished within 12 hours in order to avoid the likely onset of an emergency medical condition. B. There is not a contracted/in-network provider within the network that has the expertise, training, access to or the ability to provide the covered services that are requested by the member and which are medically necessary. • Using out-of-network providers may be necessary if networks do not include the required provider(s), or if treatment cannot be delayed for a member temporarily outside the service area who can't reach a network provider. Out-of-network reviews can determine medical necessity if a new member or existing member, whose physician is terminating, is undergoing acute out-of-network treatment. If a member needs short-term continued care to complete the acute treatment plan and make an orderly transition, services may be approved as noted in the exception below C. A newly enrolled member that is in an active course of treatment with a non-contracted provider. • Active treatment is defined as a member receiving active treatment for an acute condition in which provider continuity may prevent a recurrence of worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with a practitioner to monitor the status of an illness or disorder, provider-directed treatment, prescribe medication or other treatment or modify treatment protocol. D. A newly enrolled member that is at 24 weeks of pregnancy or greater and the obstetrical provider is with non-contracted/out-of-network provider			

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		Licensed clinicians receive requests for waiver of copayments and deductibles for out-of-network service. Staff review out-of-network requests to see if they are available in the Blue Cross & Blue Shield of Rhode Island (BCBSRI) networks or meet bullets above. Medical Directors will determine when it is appropriate to waive out-of-network-related copayments or deductibles for services not available from participating providers. **See below for application for behavioral health services.**			
3	Description of How the Factors are Used in the Design and Application of the NQTL	Covered services from non-contracted /out of network healthcare providers are reviewed for medical necessity and would be considered at the members in-network benefit level based on the member's condition and availability of an in-network provider. Requests are submitted to the utilization management support department. Licensed clinicians receive requests for waiver of copayments and deductibles for out-of-network service. Staff review out-of-network requests to see if they're available in the Blue Cross & Blue Shield of Rhode Island (BCBSRI) networks or meet bullets above. Medical Directors will determine when it is appropriate to waive out-of-network-related copayments or deductibles for services not available from participating providers, within applicable timeframes. Continuity of care requirements pursuant to state and federal law.		Covered services from non-contracted /out of network healthcare providers would be considered at the members in-network benefit level based on the member's request. Effectively, the source for there not being a contracted/in-network provider is satisfied by the statement of the member. Requests are submitted to the utilization management department. Nonclinical staff enters an approval for OON services into the Medical Management system within applicable timeframes. **Note: a Medical Necessity review is not applied.** Continuity of care requirements pursuant to state and federal law.	
4	Demonstration of Comparability and Stringency as Written	The exception policy documents the review process and criteria when a member or a provider on behalf of a member is requesting services from a non-contracted/out-of-network provider and is requesting that the services be considered at the members in-network benefit level. The policy is developed by the Payment and Medical Policy Review Committee, which is the approval body for all presented BCBSRI policies. The Committee is composed of representatives from the departments identified below, with others added as needed: 1. Utilization Management 2. Medical Director 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 **Committee membership details**			

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Title	**Qualifications**
Utilization Management Medical Director	MD
Manager of Utilization Management	RN
Manager of Medical Policy	SME
Medical Policy Analysts	RN
Manager of Payment Policy	SME
Payment Policy Analysts	SME
Director of Contracting	SME
Grievances and Appeals Unit	Senior RN/SME

The Committee evaluates and makes recommendations regarding plan administration of the proposed and/or revised policy. 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 periodic 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. 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 requests for new services, 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

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		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 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 In addition, policies are brought to BCBSRIs' Medical Technology Assessment Committee (MTAC), which is a multi-disciplinary group within Clinical integration. Composition includes 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) **<u>Policy process</u>** For medical/surgical services, requests are submitted to the utilization management support department. The determinations for medical/surgical services are made by applicable benefit area clinicians, based on their areas of expertise and knowledge of the delivery system, and medical necessity review is applied. Procedures relating to behavioral health services <u>are more favorable to members</u>. First, medical necessity criteria is not applied. Second, a review of availability is not required. Effectively, the source for there not being a contracted/in-network provider is satisfied by the statement of the member. For both behavioral health and medical/surgical services, the provider can request to be paid pursuant to a single-case agreement, in which case the contracting department follows the same case-specific rate negotiations criteria for both behavioral health and medical/surgical services.		
5	Demonstration of comparability and stringency, in operation	BCBSRI reviewed applications during a recently concluded 12month period: November 2024 – October 2025. This review found there had been **no** denials of a member's request for an exception for behavioral health services, while there had been **120** for medical/surgical services. In addition, a report is run daily to validate out of network requests are decided appropriately. If an out of network request is determined to be denied in error, a correction would be completed, and staff would be educated. This demonstrates that in practice, the processes, strategies, evidentiary standards, and other factors used to develop and apply the exceptions policy for behavioral health benefits is comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to develop and apply the exceptions policy for M/S benefits			

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6	Findings and conclusion	This analysis has demonstrated that the processes, strategies, evidentiary standards, and other factors used to develop the exceptions policy 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 the exceptions policy for 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:	**Karen Labbe** Signed by: Karen Labbe 3AA168C91C94431... **Managing Director, Utilization Review**	**Sarah Fleury** Signed by: Sarah Fleury 7F471A16436B483... **Managing Director, Behavioral Health**
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	Rosaly Cuevas **Mgr., Behavioral Health Quality** DocuSigned by: Rosaly Cuevas C1BF58CEBA16468...	
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 906280B1A3644F5... **Sonia Worrell Asare** **Managing Director, Compliance & Ethics** **Corporate Compliance Officer**	**DATE: 11/6/2025**