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.

Exclusions of Specific Treatments for Specific Conditions

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to exclusions for services 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 for medical surgical ("M/S") benefits.

		Medical/Surgical				Mental Health/Substance Use Disorder			
Steps		Inpatient, In-Network	Inpatient, Out-of-Network	Outpatient, In-Network	Outpatient, Out-of-Network	Inpatient, In-Network	Inpatient, Out-of-Network	Outpatient, In-Network	Outpatient, Out-of-Network
1	A description of the non-quantitative treatment limitation ("NQTLs");	Services may be excluded from coverage through the application of Payment policies, medical policies, and Contracting standards. (See appendix for excerpts of applicable sections) BCBSRI requires that covered services be medically necessary. "Medical Necessity" is defined as health care services that are provided to treat an illness or injury upon review by BCBSRI which are: 1. Appropriate and effective for the diagnosis, treatment, or care of the condition, disease, ailment or injury for which it is prescribed or performed; 2. Appropriate with regard to generally accepted standards of medical practice within the medical community; 3. Not primarily for the convenience of the member, the member's family or provider of such member; and 4. The most appropriate in terms of type, amount, frequency, setting, duration, supplies or level of service which can safely be provided to the member, i.e. no less expensive professionally acceptable alternative is available. Medical/Surgical example: coverage for a certain service may be dependent on the patient receiving a relevant diagnosis (e.g. *Amniotic Membrane and Amniotic Fluid*) or may be determined to be not medically necessary without regard to diagnosis (e.g. *Cranial Electrotherapy Stimulation and Auricular Electrostimulation*). Behavioral Health example: coverage for a certain service may be dependent on the patient receiving a relevant diagnosis (e.g. *Phototherapy for the Treatment of Seasonal Affective Disorder*). **(Note BCBSRI does not conduct utilization management for behavioral health services).**							
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 2025 Blue Cross and Blue Shield Association Guidelines (Chapter 4, Chapter 5) CI 1.01 UM Criteria and References LG 8.01 Plan Benefit Exclusions							

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		See Subscriber Agreement provisions pasted below							
2	Identification and Definition of the Factors and Evidentiary Standards Used to Design or Apply the NQTL	Clinical Effectiveness. These factors are defined by findings of clinical effectiveness of the treatment or service, which is sourced primarily from evidence-based evaluations by consensus panels and technology evaluation bodies, national medical professional organizations, and criteria from professional associations. BCBSRI reviews services that may be investigational or experimental. Findings in investigational or experimental cases are based on factors including published reports in authoritative, peer-reviewed medical literature, or that there may be limited evidence for the service. Proven Effectiveness. Recognition of proven effectiveness in clinical medicine exists only with: final approval for use of a specific service for a specific condition from the appropriate governmental regulatory body; and demonstrated, reliable evidence based on an entry in at least one of the three standard reference compendia or based on sound scientific studies published in authoritative, peer-reviewed medical journals permitting consensus of opinion that the service improves net health outcome, is as beneficial as any established alternatives, and that said improvement is attainable outside the investigational setting 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. 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). 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. 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. Limited Evidence (for InterQual-sourced criteria) 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 Plan benefit exclusions describe services not included in the plan's coverage.							
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 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							

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		8. Product Marketing 9. Special Investigation Unit 10. Audit and Recovery/Payment Integrity 11. Pricing and Trend Support – (NOTE: Not sure what area this is, but Payment Controls is listed below related to Pricing.) 12. Legal 13. Customer & Provider Service 14. HCL Claims (as required) 15. Policy Department 16. Payment Controls 17. Claims Operations 18. Clinical Program Operations (MHK) 19. Corporate Compliance 20. Other departments as needed							

Payment and Medical Policy Review Committee

Title	Qualifications
Utilization Management Medical Director	MD
Manager of Utilization Management	RN
Manager of Medical Policy	SME
Medical Policy Analysts	RNs
Manager of Payment Policy	SME

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

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	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 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 The Committee evaluates and makes recommendations regarding plan administration of the proposed and/or revised policies. The Committee uses the sources indicated above. The implementation phase of a medical policy is initiated upon receipt of final review and approval by the members of the Committee. 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, there is not a separate list of all policies that include an exclusion. The policy development process applies to both Medical/Surgical and Behavioral Health services. The Payment and Medical Policy Review Committee is comprised of experts in Medical/Surgical and Behavioral Health benefits. The work group meets regularly to review any new developments or emerging evidence. The cross-functional group reviews and relies on evidence-based national guidelines and criteria sourced from evidence-based evaluations by consensus panels and technology evaluation bodies, national medical professional organizations, or criteria from professional associations. The group uses the same process to determine whether to include or exclude a service. The work group takes into consideration various factors but places primary emphasis on evidence-based national research.							

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For both Medical/Surgical and Behavioral Health services, the primary source of information to determine coverage and conversely exclusions is the Blue Cross Blue Shield Association (BCBSA) Evidence Positioning System. The Evidence Positioning System incorporates an extensive process to review literature and analytical data regarding new tests and procedures as well as for reconsideration of a previous policy based on new information. EPS includes individual policies for services. BCBSRI predominantly follows the EPS. Differences in which coverage may be implemented include due to state law mandates or differences with Medicare (where Medicare is less stringent/more liberal), in which case BCBSRI follows Medicare so that there is consistent criteria (extending Medicare guidance to the commercial population), as well as due to regional alignment or local practices becoming standard of care prior to being reflected in the EPS.

The policies in EPS are reviewed periodically to include any new information. The content of those BCBSA policies is used to develop and renew BCBSRI medical policies annually, as they address the medical necessity of services. For Medical/Surgical services, there are some services where a BCBSA policy may identify circumstances in which a service may be medically necessary (suggesting medical necessity review is appropriate). However, it is possible that BCBSRI may instead choose to cover services without medical necessity review or may instead utilize InterQual medical necessity criteria in the online authorization tool. In other circumstances, BCBSRI policy for medical necessity may follow CMS guidance rather than a BCBSA policy in EPS. For Behavioral Health, no medical necessity criteria (utilization management) is applied.

Diagnosis edits (coverage for a certain service may be dependent on the patient receiving a relevant diagnosis) are similarly driven by EPS and CMS, when the service is appropriate for certain diagnosis codes and not others. The process is similar to the above, and includes input from additional work groups: Prior Authorization workgroup, and Utilization Collaboration workgroup (Medical Directors, Medical Policy Operations, Medical Management, Grievance and Appeals). The intent is to minimize the need for prior authorization when supported by evidence.

Contract exclusions, listed in Subscriber Agreement, are reviewed annually by the Exclusion Review Workgroup.

Contract Exclusion Review Stakeholders	
Department/Area	**Positions/Titles**
Actuarial	Director Actuarial Services, Manager Actuarial Services
Analytics	Managing Director Analytics
Behavioral Health	Managing Director Behavioral Health, Manager Behavioral Health Quality/Network Policy
Benefit Information Management (BIM)	Senior Business Solutions Analyst
Claims	Manager Claims Operations, Claims Business Solutions Analyst
Compliance	Chief Compliance Officer
Configuration/Facets Solutions	Manager Configuration Facets Solutions Group, Systems Analyst
Grievance and Appeals (GAU)	Director GAU, Manager GAU
Legal	Managing Director/Senior Associate General Counsel, Manager Contract Development & Analysis, Lead Contract Analyst
Medical Policy	Manager Medical Policy Operations, Medical Policy Analyst
Payment Policy/Provider Relations	Director Provider Relations, Senior Provider Payment Integrity Analyst
Pharmacy	Head of Pharmacy Services, Commercial Pharmacy Director, Director of Pharmacy Vendor Contracting
Product	Manager Product Management & Sales Enablement, Managing Director Individual & Small Business Market Segments, Product Manager, Manager Individual Segment Product & Sales
Special Investigations Unit (SIU)	Managing Director SIU & Security, Lead Fraud Investigator
Utilization Management	Managing Director Utilization Management, Manager Health Services, Manager Utilization Review

The Workgroup ensures that the process for establishing and reviewing plan benefit exclusions in our Commercial Subscriber Agreements is consistent across service categories, involves all relevant stakeholders, includes language in our Subscriber Agreements that accurately conveys the exclusion, and is clear and concise. The Legal team will document any requests to add new exclusions or change existing exclusions throughout the year. Four (4) months prior to the annual filing of rates and forms, Legal will coordinate a meeting with stakeholders to review the specific exclusions being proposed for the next filing period. The area proposing the exclusion will introduce the topic and explain the need for the exclusion. Subject matter experts will present clinical consideration, approvals or lack thereof from governmental entities, findings from other organizations, as well as other carrier coverage decisions. After stakeholder discussion and review, a determination is made by stakeholder consensus. If the exclusion is approved, Legal will draft

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		proposed subscriber agreement language and share with the stakeholders. If additional meetings to review the proposed exclusions and subscriber agreement language is necessary, Legal coordinates such meetings. The Legal team will document any requests to add new exclusions or change existing exclusions throughout the year. A final determination shall be made by the stakeholder group no more than one month prior to the annual filing deadline. If final determinations cannot be made by the stakeholder group, each group shall escalate the issue to their leadership to facilitate a decision at that higher level.							
4	Demonstration of Comparability and Stringency as Written	The Payment and Medical Policy Review 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 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. Daily reports are run to validate MH/SUD services; contract exclusions are denied appropriately. Contract exclusions are becoming inventoried to document the supporting information for each of the exclusions.							
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. When EPS indicates coverage for a service for BH with criteria, BCBSRI follows the recommendation for coverage and does so without imposing medical necessity review (utilization management). Diagnosis edits are applied when the diagnosis is non-specific (for example, metabolism, and not specific to a particular indication), and when such information indicates BH then utilization management is not applied. *(As a further example of compliance, the EPS states some genetic tests may be medically necessary for BH conditions with criteria, however BCBSRI allows coverage without applying utilization management.)* Plan benefit exclusion language has been submitted to the Office of the Health Insurance Commissioner for review and approval on an annual basis.							
6	**Findings and Conclusions**	The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply out-of-network reimbursement rates 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 out-of-network reimbursement rates to M/S benefits; and (2) the [Plan or Issuer] complies with the relevant data requirements under the MHPAEA Final Rules. This analysis has demonstrated that the processes, strategies, evidentiary standards, and other factors used to develop exclusions 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 exclusions for M/S benefits.							

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Analysis Reviewed/Approved by BCBSRI's Mental Health Parity Governance Committee (PGC)	**x** Signed by: 3AA168C91C94431...	
Analysis Performed By:	**Karen Labbe** **Managing Director, Utilization Management**	**Linda Dilorenzo** **Mgr., Health Services** Signed by: 28B0AC818C534F7...
	Victor Pinkes **Senior Medical Director** Signed by: 11D60EE37BB2463...	**Rosaly Cuevas** **Mgr., Behavioral Health Quality** DocuSigned by: C1BF58CEBA16468...
	Jennifer Dolben **Manager, Clinical Program Oversight** Signed by: CB291B202A7A4EB...	**Andrea Camara** **Mgr., Medical Policy Operations** Signed by: 2D5544DC86AD4BE...
Implementation Date:	**1/1/2026**	
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** **Managing Director, Compliance & Ethics** **Corporate Compliance Officer**	**DATE:**

Attachments to NQTL:

Attachment 1 – CN 5.0 Medical and Payment Policy Development and Implementation

Attachment 2 – CI 1.01 Utilization Management Criteria and Reference Policy