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").

BCBSRI's Credentialing Standards for Participation in its Network - Health Delivery Organizations & Professional Providers

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply credentialing standards, for providers of 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.

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		Medical/Surgical		Mental Health/Substance Use Disorder	
Steps		**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
1	A description of the non-quantitative treatment limitation ("NQTLs")	Credentialing is detailed review and verification of a health care practitioner's qualifications and experience. Credentialing protects the safety of patients and collects information for practitioner directories. Credentialing Standards: Credentialing standards are not referenced in the Summary Plan Description or Certificate of Coverage, rather, they are contained and referenced in documents described below. These credentialing standards sections apply to both M/S benefits and MH/SUD benefits, any differentiation between M/S and MH/SUD benefits (and classifications) is noted.			
		The provider admissions NQTL applies to all in-network benefits covered under the BCBSRI network. The current Health Delivery Organization (HDO) network* is closed for limited HDO providers outlined in BCBSRI's closed network policy and procedure; all credentialing applications received from HDOs are submitted to the Network Management Team for review to determine if the HDO will be allowed in our network as a participating provider using the guidelines in BCBSRI's policy and procedure. All applicants must meet	The provider admissions NQTL applies to all in-network benefits covered under the BCBSRI network. The professional provider network is open to any professional provider who meets BCBSRI's credentialing and contracting standards. The current Health Delivery Organization (HDO) network is closed for limited HDO providers outlined in BCBSRI's closed network policy and procedure; all credentialing applications received from HDOs are submitted to the Network Management Team for review to determine if the HDO will be allowed in our network as a participating	The provider admissions NQTL applies to all in-network benefits covered under the BCBSRI network. **The Behavioral Health Network is "open**" - it is not closed to new Health Delivery Organizations (Behavioral Health Care Organization) meeting the credentialling and contracting standards.	The provider admissions NQTL applies to all in-network benefits covered under the BCBSRI network. BCBSRI's Behavioral Health professional provider network is open to any professional provider meeting the credentialing and contracting standards. *National telemedicine providers are described below.*

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		Medical/Surgical		Mental Health/Substance Use Disorder	
Steps		**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
		credentialling and contracting standards. **A Health Delivery Organization (HDO) is an organization, or group of related organizations, involved with the delivery of healthcare services. BCBSRI defines an HDO as a healthcare provider that is not an individually licensed practitioner contracted and credentialed separately by BCBSRI. Examples of HDO's are: Home Care, Home Infusion, Ambulance, Laboratory, Durable Medical Equipment, Ambulatory Surgical Centers, Hospice, Hospitals, Independent Diagnostic Testing Facilities, Dialysis, Sleep Labs (non-hospital or physician owned), and Urgent Care Centers.*	provider using the guidelines in BCBSRI's policy and procedure. All applicants must meet credentialling and contracting standards.		
	Policies / Guidelines / Other Documents Describing Credentialing Standards	Credentialing standards appear or are described in the following documents: Provider Credentialing and Recredentialing Policy (published externally via BCBSRI.com) CR 2.01.00 Credentialing Verification Process – Non Physician Professional Providers (internal policy in Archer) CR 2.01.01 Credentialing Verification Process – Physicians (internal policy in Archer) CR 2.01.01B Incomplete Credentialing/Re-Credentialing Applications (internal policy in Archer) CR 2.01.01C Credentialing and Re-Credentialing Verification Methods-Physician. (internal policy in Archer)			

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Medical/Surgical			Mental Health/Substance Use Disorder	
Steps	**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
	CR 2.01.01D Credentialing and Re-Credentialing Verification Methods-Non-Physician Professional Providers (internal policy in Archer). CR 2.01.02 Credentialing/Recredentialing Approval Process (internal policy in Archer). CR 2.01 Initial Credentialing Requirements – Physicians and Non Physicians Primary Care Providers (internal policy in Archer). CR 2.02 Transitional Credentialing Status (internal policy in Archer) CR 2.03 Initial Credentialing Requirements – Non Physician Professional Providers (internal policy in Archer) CR 2.05 Primary Source Verification and Modification of Credentialing Information (internal policy in Archer) CR 3.01.01 Re-Credentialing Verification Process (internal policy in Archer). CR 3.01.01C Noncompliance with Re-Credentialing Processes (internal policy in Archer) CR 3.01.02 Re-Credentialing Verification Process – Non Physician Professional Providers (internal policy in Archer) CR 3.01 Re-Credentialing Requirements for Practitioners (internal policy in Archer) CR 5.01 Credentialing File Organization (internal policy in Archer) CR 6.01 Health Delivery Organization (HDO) Credentialing/Re-Credentialing Requirements (internal policy in Archer) CR 7.04 Ongoing Internal Monitoring of Sanctions for Credentialed Physicians/Providers (internal policy in Archer) CR 9.01 Office Site Review Process (internal policy in Archer) The policies noted above are submitted in support of NCQA accreditation.			

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		Medical/Surgical		Mental Health/Substance Use Disorder	
Steps		**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
2	Identification and Definition of the Factors and Evidentiary Standards Used to Design or Apply Credentialing Standards	Credentialing standards are imposed by or arise from: • State law (Rhode Island General Laws), ○ RI GL § 27-18.8-3 Health Accessibility and Quality Assurance Act, Certification of network plans, section d, Contracting and credentialing requirements. • Federal and state regulators (the Office of the Health Insurance Commissioner, CMS), ○ Medicare Managed Care Manual, Chapter 6, Section 60.3 Credentialing Monitoring and Re-Credentialing. • Industry Standards (Blue Cross Blue Shield Association (BCBSA) and ○ Chapter 5 Claims Filing Rules from the BCBSA ○ Category 4 _ Participation and Eligibility from the BCBSA • The National Committee for Quality Assurance (NCQA), including for timeliness of processing of applications. ○ NCQA Standards for Accreditation of health Plans			
3	Description of How the Factors are Used in the Design and Application of the NQTL	BCBSRI's credentialing and re-credentialing process follows CMS regulations, Office of the Health Insurance Commissioner requirements and National Committee of Healthcare Compliance (NCQA) standards and guidelines. The types of providers BCBSRI credentials include physicians (MDs, DOs, DPMs, DMDs, NPs, and DCs) who provide healthcare in ambulatory settings, individual or group practices, facilities, or telemedicine, and hold a valid license to practice. BCBSRI's credentialing and recredentialing criteria include: the provider's application with a current attestation, a current unrestricted state medical license and acceptable medical licensure history, disclosure of all sanctions, current unrestricted DEA certificate, satisfactory work history, board certification, education and training, acceptable history of professional liability claims, and proof of adequate professional liability insurance coverage. BCBSRI ensures all items of the application are verified within timeframes defined by CMS, OHIC, and NCQA, and recredentials providers well within the required time limits (NCQA requires recredentialing is performed within three years, BCBSRI recredentials providers at the two-year mark to allow sufficient time to follow up on any omitted or outdated items in the application, and for any necessary termination procedures, as well as to allow time for unexpected issues, while remaining compliant with the three-year limit). When all credentialing/re-credentialing documents have been obtained and			

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Medical/Surgical			Mental Health/Substance Use Disorder	
Steps	**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
	requirements are satisfied and/or discrepancies are clarified, they are placed in the physician's/provider's electronic credentialing file. For initial credentialing, providers complete an online provider enrollment request which is accessible via BCBSRI.com to initiate the credentialing process. BCBSRI automatically initiates provider recredentialing on the two-year anniversary of the last credentialing/recredentialing date on file. Providers are notified via certified mail that the recredentialing process will begin and are also sent a recredentialing checklist that provides them with the opportunity to update all required information via CAQH (their online application). BCBSRI will reach out via email or phone call to request any missing information. Once the provider is approved for recredentialing, a notification letter is mailed to the provider to advise them that they have been recredentialed with BCBSRI. BCBSRI's credentialing/re-credentialing process is conducted in a nondiscriminatory manner. All members of the Credentialing Committee are required to sign a Nondiscriminatory Process Policy, which confirms that the credentialing and re-credentialing processes have been conducted in a nondiscriminatory manner. In addition to having committee members sign the Nondiscriminatory Process Policy upon initial participation and annually thereafter, an annual audit is conducted to ensure that credentialing decisions were not conducted in a discriminatory manner. Once all credentialing information is received, the following steps are taken to approve (or deny) providers into the BCBSRI Network: • The Credentialing Department reviews the files for completeness prior to referring it to the Medical Director or their designee, the Credentialing Committee, or qualified physician for review. • The Medical Director or their designee may review completed credentialing applications and approve clean files. The Medical Director or their designee (or qualified physician) may also make recommendations to the Credentialing Committee for files with areas of concern regarding the approval/denial of initial applicants and/or approval of ongoing participation for re-applicants or recommendation of termination of contracted physicians/providers seeking re-credentialing. They also note those applicants that require discussion prior to approval (all recommendations for denial or termination require discussion). o If a file is determined to be clean, the Medical Director or their designee may act as the credentialing body and may approve the file by a unique electronic sign off documenting approval. o Committee members present at the committee meetings, review/discuss the physicians/providers to be credentialed or re-credentialed. • Regardless of any sanctions, disciplinary actions, restrictions, professional liability claims, or other credentialing issues, the Medical Director or their delegate and the Credentialing Committee will review the credentials of all new applications for			

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Medical/Surgical			Mental Health/Substance Use Disorder	
Steps	**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
	physicians/providers with issues. The meeting agenda is prepared listing each applicant and applicants are presented in categories: applicants where all standards are met and applicants with standards requiring committee action. o After their discussion, the voting members of the Credentialing Committee may vote to: ▪ Hold the file while awaiting additional information ▪ Approve the physician/provider, or ▪ Deny initial appointment, or ▪ Terminate and end continued participation. o In the event a physician/provider is approved but further action is required, a corrective action plan is to be developed outlining the specific action to occur, timeframes for completion and who is responsible for conducting any follow-up activities (e.g., Quality Management (QM), the Dental Department, or Clinical Affairs). o If a provider is denied recredentialing, they receive a 90-day notice prior to termination which also includes the reason for denial and BCBSRI's Fair Hearing Policy for appeal. o If there are no concerns or issues raised during the committee review/discussion, the voting members of the committee vote to approve the physicians/providers. Approval is based on a majority vote. • Determination is made on all professional providers' new applications within forty-five (45) days of receipt of a complete application. All recredentialing is completed within 3 years of the month of their last credentialed date. • BCBSRI also follows strict guidelines regarding provider rights, which include provider's right to: review information submitted to support their credentialing application, correct erroneous information, and receive the status of their credentialing or recredentialing application upon request. • Approvals for credentialing become effective on the day after approval by the Credentialing Committee. Approvals for recredentialing result in no change to the contracted status of the physician/provider. Once a provider is approved for initial participation by the Credentialing Committee, the Credentialing Department (within 45 days from the receipt of a complete application) will update the Credentialing Tracking System with the final action taken (approved, denied) including the date of the decision, approved specialty, and any other changes to the application as a result of the Credentialing Committee's decision. The Credentialing Department also enters the provider's credentialing into Symplr Provider, BCBSRI's database for provider credentialing information. As noted, any credentialing/recredentialing files which include negative or questionable issues as judged by the Medical Director or their designee are presented to the Credentialing Committee for discussion. Examples of issues include: the provider doesn't meet BCBSRI's standards, professional liability or professional sanctions are discovered, discrepancies in the provider application and			

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Medical/Surgical			Mental Health/Substance Use Disorder	
Steps	**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
	primary source verification are discovered, or ongoing quality, complaint, Utilization Management, or contractual issues are identified. The list of credentialing criteria is publicly available via bcbsri.com. If the committee requires additional expertise on a practitioner, the finding is sent out for outside review with an outside vendor or a like practitioner in our network. The practitioner information sent to our vendor or like practitioner in our network is de-identified, and experts in the practitioner in question's specialty will review the finding before making a recommendation. Further, if additional information is requested: • The credentialing file is held until the information is received or held for 30 calendar days, whichever is earlier. A file is no longer on hold once it is identified as submitted to the Credentialing Committee for review. • The credentialing file is referred back to the credentialing specialist who requests and follows up on any required information. • Upon receipt of the requested information, if the response is complete, the file is presented again at the next Credentialing Committee meeting. If the response is not complete the Credentialing Department contracts the provider requesting the required information. If the clinical and/or administrative information that was requested has not been received, then the following steps are to occur: *For Initial (New) Credentialing:* • If there is no response within 30 calendar days of the written request, the credentialing specialist will discontinue the credentialing process. This will be documented in Credentialing Tracking System and in the electronic physician/provider file. • The Credentialing Department prepares and sends a "Credentialing Discontinuation E-mail" to the provider notifying them that the application process has been administratively discontinued. The provider may reapply in the future, though they must include any information or documentation that was requested regarding the negative or questionable issues. A copy of the e-mail is placed in the Credentialing Tracking System. *For Recredentialing:* • Should the information requested be received, if the response is complete, it is presented again at the next Credentialing Committee meeting. If the response is not complete, an e-mail is sent requesting the required information. • If there is no response within five (5) calendar days of the initial written request, the Credentialing Department sends a second request to the physician/provider to notify him/her that the information requested has not yet been received. After five (5) additional days, if no response is received a final e-mail is sent requesting the missing information. If no response			

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		Medical/Surgical		Mental Health/Substance Use Disorder	
Steps		**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
		within 5 days from the final request, this information is presented to the Credentialing Committee with a recommendation to terminate the provider participation. In the event that the Credentialing Committee votes for termination of a provider's participation, the following occurs: • The Credentialing Department prepares and sends notification of termination to the impacted provider. (The notification of recommended termination to HDO facilities are handled by the Credentialing Department in conjunction with the Contracting Administrator) *New Applicant Providers:* • The Credentialing Department, in conjunction with the Medical Director or their designee, sends a formal letter via certified mail within 45 days of receipt of a complete application to advise the applicant of the decision to deny their participation. The letter includes information on the reasons for denial and the applicant's appeal process. • The Credentialing Department updates the Credentialing Tracking System with the final action taken. • The Credentialing Department places the file in the designated folder on the Credentialing SharePoint site for terminated/discontinued applications. *Providers Being Recredentialed:* • The Credentialing Department updates the Credentialing Tracking System and added to the Appeals Log with the final action taken. • A 90-day termination letter or an Immediate Needs Termination letter is sent to the provider with any applicable appeals rights attached. • Once the appeals process has been exhausted, a Change/Termination form is completed by the Credentialing Department in the Sharepoint. • A Provider Database specialist updates the BCBSRI's database to reflect a terminated status. A credentialing specialist also updates Symplr Provider to reflect a terminated status.			

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		Medical/Surgical		Mental Health/Substance Use Disorder	
Steps		**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
		Between recredentialing cycles, BCBSRI also follows processes for ongoing monitoring of provider sanctions, complaints, and quality issues. BCBSRI and the credentialing department takes action against providers when it identifies issues. The Credentialing Department reviews sanctions monitoring reports from providers located in the States of RI, MA, and CT and reviews these reports once per week with data extracted from: the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE), the Federal Office of the Inspector General Office of Personnel Management (OPM), and the Government Services Administration (GSA) Excluded Parties List System (EPLS) and System for Award Management (SAM). Further, the BCBSRI Lead Provider Network Reporting Analyst also reviews the OIG Reports on a monthly basis to determine if any providers within our network are identified for review and/or possible removal from our network. Any findings would be reported monthly. The Credentialing Department compares practitioners found in any/all the above reports to the Credentialing Tracking System. A potential list of matches is generated and reviewed, assuring that the information is reviewed within 15 calendar days of the federal agency reports release. If an active participating practitioner match is found on the Credentialing Tracking System, the Credentialing Department informs the Senior Medical Director or designee who presents the provider at the next scheduled meeting of the Credentialing Committee for review for appropriate actions. There are multiple follow up actions: • Sanction is reviewed and the committee determines no action is needed. This is documented in the Credentialing Committee Meeting minutes. • Sanction is reviewed and the Credentialing Committee recommends a letter be sent to the provider. The Credentialing Team will work with the Medical Director or his designee to finalize and send the letter. • Sanction is reviewed and the Credentialing Committee determines the provider should be terminated. Provider is sent a termination letter with a 90-day appeal timeframe per standard Credentialing process. The provider will remain active until the 90-day appeal period elapses. • In cases of debarment or immediate need/danger to the public, the Medical Director or designee is notified, and the provider is automatically terminated immediately with expedited appeal rights. In cases of OIG sanctions, Medicare products are immediately terminated with commercial products processed per the Credentialing Committee's direction. The following steps are followed based on the decision of the Credentialing Committee: • The Credentialing Department completes a change form to reflect the debarred or sanctioned status and effective date. • Provider Database electronically notifies the departments/units below that the provider has been deemed debarred or sanctioned from the Medicare/Medicaid programs. The form includes the debarred or sanctioned date.			

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		Medical/Surgical		Mental Health/Substance Use Disorder	
Steps		**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
		• The Credentialing Department adds the monthly findings, if applicable to an electronic memo and forwards to the Quality Management (QM) Department and Accreditation for tracking in the central repository. • If the Credentialing Committee makes the decision to terminate, the Credentialing Department prepares and mails the termination letter and creates an appeals log entry for tracking purposes. After the appeals process has been exhausted, the Credentialing Department updates the change form with the appropriate termination effective date and reflects all lines of business. The Credentialing Department then notifies the appropriate staff responsible to end date the provider record from the credentialing tracking system and requests via the change form. • The Credentialing Termination will update the terminated provider's end date in the Credentialing Tracking System after the termination is decided at Credentialing Committee and the change is captured in the credentialing tracking system.			
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 credentialing 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. The credentialling files are well documented and maintained, pursuant to NCQA. The policies are submitted for accreditation and have been approved by both the internal NCQA accreditation team and by external NCQA reviewers, who review random samples of actua files. The same policies, checklists, applications, and other documents and procedures apply to both Medical/Surgical and Behavioral Health. There is a Credentialing Committee with membership including: • BCBSRI Medical Director • BCBSRI Sr Operations Outsourcing Analyst • BCBSRI Managing Director of Provider Services • Additional BCBSRI physician reviewers including other Medical Directors or outside consultants. • At least six additional community-based providers, including primary care and specialist providers, including behavioral health professionals. All providers must participate in the BCBSRI network. • BCBSRI Quality Management (QM) representative • Representatives from the BCBSRI Credentialing Department and other individuals (staff, individuals involved in			

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Medical/Surgical			Mental Health/Substance Use Disorder	
Steps	**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**

delegated arrangements and others) are invited to attend committee meetings as determined by the Provider Credentialing Committee

Credentialing Committee

Title	**Qualifications & Specialty**
Augustine Manocchia, MD	Medical Director, Chairperson
Andrew Nathanson, MD	Emergency Medicine
Lisa Shea, MD	Psychiatry
Anthony Berghelli, DO	Internal Medicine/PCP
John Leimert, MD	Pediatrics
Sidney P Migliori, MD	Orthopedic Surgery
Linda Young, NP	NP/PCP
Mary Ellen Moskal	Managing Director, Provider Services
Norberto Lobao	Sr Ops Outsource Analyst
Rakesh Hamsbalan	Senior Manager
Elizabeth James	Quality Management Analyst
Jennifer Brooks	Senior Analyst
Lauren Lovett	Provider Data Integrity Specialist
Mohammed Arif Anifa	Senior Team Lead

The Credentialing Committee reviews information from the National Plan and Provider Enumeration System, National Practitioner Database (NPDB), public records, State licensure information including state issued sanctions or reprimands including from the RI Department of Health, CMS Preclusion List, and the Office of the Inspector General (OIG) Reporting, as well as qualifications for any requested change in provider status (add a sub- specialty, change in specialty designation).

All known sanctions or malpractice cases are reviewed by the Credentialing Committee. The National Practitioner Database would identify any malpractice cases that are not self-reported. The process also considers the practitioner's failure to maintain or supply information deemed required as part of a complete recredentialing application (It is the responsibility of providers to maintain all

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		Medical/Surgical		Mental Health/Substance Use Disorder	
Steps		**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
		credentialing information in a status to support recredentialing activity). All Office of the Health Insurance Commissioner ("OHIC") requirements for a complete provider participation application are verified. The development and application of BCBSRI's credentialing criteria is based on state law and regulations, industry standards, and other business criteria. The same factors and processes are applied equally to medical/surgical and behavioral health providers. Regarding location: • The applicant/provider maintains an address within BCBSRI's defined service area and meets all credentialing requirements. Our service area consists of all zip codes within the State of RI and selected zip codes within contiguous counties within Massachusetts and Connecticut. The list is maintained with the Blue Cross Blue Shield Association. (BCBSA). • For national telemedicine providers, BCBSRI follows BCBSA rules which allow contracting with those providers, and with additional factors including the vendor's provision of services enhancing those available locally and the vendor's assumption of credentialling obligations. o The BCBSA defines a policy for national telemedicine provider groups both (medical/surgical and behavioral health providers) which allows for contracting directly with a local Blue Cross/Blue Shield plan. The determination if BCBSRI will contract with a national telemedicine provider is determined on an individual basis. Factors that are used in determining if BCBSRI will contract with a national telemedicine provider are; does the telemedicine provider offer unique and/or differentiating services and/or programs that are not available through a current BCBSRI national telemedicine provider or through its local or national brick and mortar network, the national telemedicine provider offers access to services to BCBSRI members locally and or nationally that cannot be met by existing telemedicine providers or brick and mortar providers, the national telemedicine provider offers services and/or programs that align with a larger BCBSRI initiative and/or health management program which the national telemedicine provider will assist in making the larger initiative successful or may be a key component of the initiative. If BCBSRI determines that it will accept a national telemedicine provider into its network, BCBSRI business rule would be to delegate credentialing to these national telemedicine providers. BCBSRI will oversee the national telemedicine providers credentialing process to ensure compliance with all state, state, federal and accreditation requirements e.g. NCQA as well as all BCBSRI requirements. • Remote ancillary providers (e.g., laboratories, durable medical equipment, and specialty pharmacies), following BCBSA guidelines, can have an address/be located outside of RI or contiguous counties. There is a BCBSA and BCBSRI exception to the "service area" rule for these provider types. These providers operate and deliver services in RI, however the physical location of their services e.g., a main laboratory may not be located in RI.			

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<table>
<tr><th colspan="2" rowspan="2">Steps</th><th colspan="2">Medical/Surgical</th><th colspan="2">Mental Health/Substance Use Disorder</th></tr>
<tr><th>Inpatient</th><th>Outpatient</th><th>Inpatient</th><th>Outpatient</th></tr>
<tr><td>5</td><td>A demonstration of comparability and stringency, in operation;</td><td colspan="4">
At Mental Health Parity Governance Committee meetings, the following report isa reviewed:
The Annual Non-Discriminatory Audit as well as the quarterly updates reflect quarter to date activity. This report documents providers terminated from the BCBSRI network, provides denied access to the BCBSRI and provider who had requested status changes denied. The report includes the reasons why the action was taken.

The quarterly and year to date provider movement report reflects the additions and termination totals with our primary care, behavioral health and specialist provider populations.

The credentialling and re credentialing data finds the approval rate percentages to be 100% for both medical/surgical and behavioral health providers

<u>Initial Credentialing:</u>
<table>
<tr><th>Provider Type</th><th># of providers applied</th><th># of providers approved</th><th># of providers denied</th><th>Average Turnaround Times</th><th>Remarks</th></tr>
<tr><td>HDOs</td><td>21</td><td>13</td><td>0</td><td>22</td><td>Out of 21 that applied 13 were approved. The balance of 8 (1 is pending for Committee approval and 7 are in process).</td></tr>
<tr><td>BH Providers</td><td>448</td><td>299</td><td>0</td><td>18</td><td>Out of 448 that applied 299 were approved. The balance of 149 (14 with Verisys, 2 are approved pending, 17 for Committee approval, 26 with HCL, 5 with HCL Database, 1 pending withdrawal, 11 providers withdrew, 73 were discontinued.</td></tr>
<tr><td>All non BH providers</td><td>1015</td><td>690</td><td>0</td><td>21</td><td>Out of 1015 that applied 690 were approved. The balance of 325 (66 with Verisys, 5 are approved pending, 42 for</td></tr>
</table>
</td></tr>
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Medical/Surgical			Mental Health/Substance Use Disorder	
Steps	**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**

						Committee approval, 56 with HCL, 6 with HCL Database, 17 are transitional, 3 approved pending withdrew, 14 providers withdrew and 116 were discontinued.

Please note: There were no providers denied in 2025. However, we have one provider denied at the 1/14/2025 committee, whose submission was received in the month of December 2024 and was brought back to Feb 11, 2025, committee and was approved.

Re-Credentialing:

Provider Type	# of providers applied	# of providers approved	# of providers denied	Average Turnaround Times	Remarks
HDOs	167	88	0	22	Out of 167 reviewed, 88 were approved. The balance of 79 (5 were termed, 55 were in process with HCL, 18 pending for Committee approval and 1 in appeal process).
BH Providers	663	565	0	17	Out of 663 reviewed, 565 were approved. The balance of 98 (4 were termed, 19 were in process with Verisys, 11 were in process with HCL, 44 were awaiting approval as clean recredentialing files, and 20 in appeal process).
All non BH providers	2175	1756	0	17	Out of 2175 reviewed, 1756 were approved. The balance of 419 (47 were termed, 61 were in process with Verisys, 78 were in process with HCL, 174 were awaiting

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		Medical/Surgical		Mental Health/Substance Use Disorder	
Steps		**Inpatient**	**Outpatient**	**Inpatient**	**Outpatient**
					approval as clean recredentialing files, and 59 in appeal process).
6	Findings and conclusion	This analysis has demonstrated that the processes, strategies, evidentiary standards, and other factors used to develop network participation 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 network participation standards for M/S benefits.			

Analysis Reviewed/Approved by BCBSRI's Mental Health Parity Governance Committee (PGC)		**Implementation Date: 1/1/2026**
Analysis Performed By:	**09/29/2025** **Mark Bevelander** **Director, Network Contracting** DocuSigned by: Mark Bevelander 036E7DA30D374D4... **Rosaly Cuevas** **Mgr., Behavioral Health Quality** DocuSigned by: Rosaly Cuevas	**Mary Ellen Moskal** **Mng., Director Provider Services** DocuSigned by: Mary Ellen Moskal AF27958F2DBD4DA...
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: 09/29/2025**

Blue Cross & Blue Shield of Rhode Island (BCBSRI) Mental Health Parity and Addiction Equity Act - NQTL Comparative Analysis