

STATE OF RHODE ISLAND
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVENUE,
BLDG 69-1 CRANSTON, RI 02920

In Re: Examination of Health Insurance Carrier Compliance)
With Network Adequacy and Provider Directory) OHIC-2019-9
Laws and Regulations)

Examination Report of Blue Cross Blue Shield of Rhode Island, in accordance with
R.I.G.L. § 27-13.1-5(b).

In re Examination of Health Insurance Carrier Compliance with Network Adequacy and Provider Directory Laws and Regulations, Docket No. OHIC-2019-9

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February 3, 2022

Honorable Patrick Tighe

Health Insurance Commissioner

State of Rhode Island

Dear Commissioner Tighe:

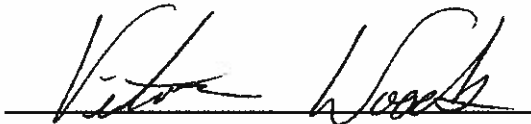
In accordance with your instructions and pursuant to statutes of the State of Rhode Island, a targeted Market Conduct Examination was conducted in order to ascertain compliance with applicable statutes and regulations relating to Network Adequacy and Provider Directory accuracy by all four major health insurance carriers in Rhode Island. This Examination Report addresses compliance by Blue Cross Blue Shield of Rhode Island.

The examination was conducted by Emily Maranjian, OHIC General Counsel, Victor Woods, OHIC Health Economic Specialist, Linda Johnson, LLC, James Lucht Consulting, and Risk & Regulatory Consulting, LLC.



Emily Maranjian, Esq.

RI Office of the Health Insurance Commissioner



Victor Woods, Health Economic Specialist

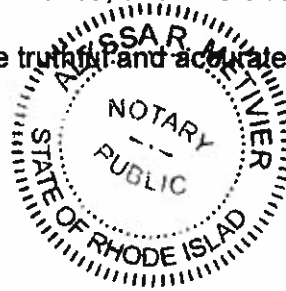
Office of the Health Insurance Commissioner

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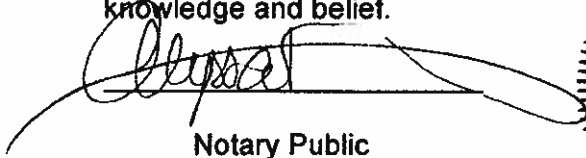
On this 3 day of February, 2022, before me, the undersigned notary public, personally appeared Emily Maranjian, personally known to the notary to be the person who signed the Examination Report in my presence, and who swore or affirmed to the notary that the contents of the document are truthful and accurate to the best of her knowledge and belief.



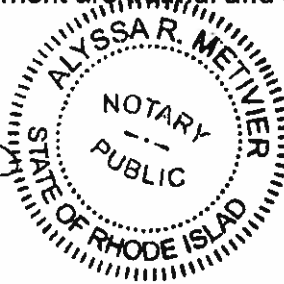
Notary Public



On this 3 day of February, 2022, before me, the undersigned notary public, personally appeared Victor Woods, personally known to the notary to be the person who signed the Examination Report in my presence, and who swore or affirmed to the notary that the contents of the document are truthful and accurate to the best of his knowledge and belief.



Notary Public



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1. Introduction

This market conduct examination ("Examination") commenced with a Warrant of Examination issued by the Commissioner of the Office of the Health Insurance Commissioner ("Commissioner") on September 3, 2019. The Commissioner appointed as Examiners (among others) Victor Woods, Health Economic Specialist, Office of the Health Insurance Commissioner (OHIC); Emily Maranjian, Esquire, OHIC General Counsel; Linda Johnson L.L.C.; James Lucht Consulting; and Risk & Regulatory Consulting, L.L.C. The Examination is a targeted examination of the four largest health insurance carriers in the Rhode Island (RI) commercial insurance market: Blue Cross Blue Shield of Rhode Island ("Blue Cross"), Neighborhood Health Plan of RI ("Neighborhood"), Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively "THP"), and UnitedHealthcare Insurance Company and UnitedHealthcare of New England, Inc. (collectively "United") (collectively the "Carriers").

The purpose of the Examination was to review the Carriers' compliance with state and federal laws and regulations relating to the adequacy of Carrier networks and the accuracy of Carrier Provider Directories. Such compliance is paramount to ensuring the Carrier's beneficiaries have timely access to covered health care services without delay.

This examination report addresses findings of non-compliance and/or non-compliant practices of Blue Cross. This examination report does not purport to identify every instance or practice of non-compliance relative to Network Adequacy

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and accuracy of Provider Directories during the Exam Period¹. Any failure to identify a non-compliant practice should not be considered approval or acceptance of said practice by OHIC and does not prohibit or limit in any way future enforcement of laws and regulations relating to Network Adequacy and Provider Directories.

2. Applicable statutes and regulations

- A. Complaint and Grievance Process. Pursuant to R.I.G.L. § 27-18.8-3 (b) (4) and 230-RICR-20-30-9.6 (A) (1–4), carriers are required to maintain a grievance and complaint process that includes a mechanism where a beneficiary², a beneficiary's authorized representative or a provider can seek timely resolution of written and oral complaints. As set forth in R.I.G.L. § 27-18.8-2 (8) and 230-RICR-20-30-9.3 (A)(9), a “complaint” or “grievance” means an oral or written expression of dissatisfaction by a beneficiary, authorized representative or provider. According to these provisions the grievance and complaint process (hereinafter, the Complaint Process) must include: resolution of grievances or complaints (hereinafter, complaints) within 30 days, annual communication explaining the Complaint Process to beneficiaries and providers, and an accurate monitoring and reporting process. Failure to provide a compliant Complaint Process compromises the complainant's right to a timely and reasonable resolution to their complaint.

¹ This report defines the Exam Period as the calendar date range set forth in each Information Data Request (located in Appendix A) for the gathering of data and information.

² This report uses the term “beneficiary” and “member” interchangeably

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Carriers are also required, as set forth in R.I.G.L. § 27-18.8-6 and 230-RICR-20-30-9.10 and consistent with reporting instructions³, to report by category and content, all complaints to OHIC. A carrier's failure to correctly define, categorize, and report complaints brings into question the validity of the carrier's reported complaint volume and content, which may include information pertinent to the accuracy of a carrier's Provider Directory or the adequacy of its network.

- B. Carrier Oversight. Carriers are obligated, pursuant to R.I.G.L. § 27-18.8-3 (b), 230-RICR-20-30-9.5 (B) and 230-RICR-20-30-9.6 (E), to develop, implement and maintain a quality assurance program that provides oversight of all their activities, whether delegated or not. This required ongoing oversight includes processes to regularly evaluate carrier activities (e.g., maintaining an accurate Provider Directory, maintaining an adequate professional and facility provider network, compliant complaint management, and ensuring behavioral health (BH) parity) and determine whether these carrier activities are being performed in a manner that maintains availability, accessibility, continuity and quality of services for its beneficiaries and ensures that such activities do not adversely affect the delivery of covered services. Failure to provide effective oversight of such activities negatively impacts a beneficiary's ability to access and obtain necessary covered services.

³ See OHIC's "Annual Network(s) Plans Reporting Form" issued by OHIC on June 27th, 2018 providing instructions to carriers regarding the tracking of complaints as of January 1, 2019.

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C. Behavioral Health Parity. Carriers are required to provide coverage for BH disorders⁴ at parity with medical-surgical (M/S) services according to 42 U.S.C. § 300gg-26, 45 CFR 146.136, 45 C.F.R. § 146.136 (c) (4) (ii) (D), R.I.G.L. § 27-38.2-1 (a) (c) & (d) and 230-RICR-20-30-9.6 (F). These rules specify that carriers shall not impose non-quantitative treatment limitations for the treatment of BH disorders unless the processes, strategies, evidentiary standards or other factors used in applying non-quantitative treatment limitations⁵, as written and in operation, are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying limitations for M/S benefits. Furthermore, carriers are also prohibited from imposing additional

⁴ This report refers to “mental health or substance use disorders” as “Behavioral Health disorders” or “BH disorders”. Rhode Island General Laws §27-38.2-2(5) states that “‘Mental health or substance use disorder’ means any mental disorder and substance use disorder that is listed in the most recent revised publication or the most updated volume of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICO) published by the World Health Organization; provided, that tobacco and caffeine are excluded from the definition of “substance” for the purposes of this chapter.”

⁵ R.I.G.L. § 27-38.2-2 (6) defines “Non-quantitative treatment limitations” as “(i) Medical management standards; (ii) Formulary design and protocols; (iii) Network tier design; (iv) Standards for provider admission to participate in a network; (v) Reimbursement rates and methods for determining usual, customary, and reasonable charges; and (vi) Other criteria that limit scope or duration of coverage for services in the treatment of mental health and substance use disorders, including restrictions based on geographic location, facility type, and provider specialty.”

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standards for BH providers when admitting them for participation in the carrier's network.

Rhode Island's parity law, RIGL § 27-38.2, was originally enacted in 1994 and amended in 2014 to reflect the federal BH parity law enacted in 2008 and the final federal regulations adopted in 2013. The following core legal principals and parity obligations for carriers have remained the same throughout the Exam Period: (1) carriers must provide coverage for the treatment of mental health and substance use disorders, and (2) such coverage must be provided under the same terms and conditions as the coverage provided for other illnesses and diseases.

Federal law also requires parity in coverage between BH and M/S conditions. Among other requirements, federal law prohibits the application of non-quantitative treatment limitations unless the BH limitation is comparable to, and applied no more stringently than, the treatment limitation applicable to M/S treatment, as set forth in 42 U.S.C. § 300gg-26. Federal regulation further requires coverage of medically necessary BH services in the individual and small group markets defined in 45 C.F.R. § 156.110 (a) (5).

Additionally, as set forth in 45 C.F.R. § 146.136 (c) (4) (ii) (D), carriers are prohibited from imposing additional standards for BH providers when admitting them for participation in the carrier's network.

- D. Monitoring Network Adequacy. Carriers are obligated to provide an adequate network as set forth in R.I.G.L. § 27-18.8 Health Care

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Accessibility and Quality Assurance Act. A carrier must ensure its networks of contracted providers are sufficient in number and in scope of clinical specialties to ensure timely access to the full scope of covered health care services to its beneficiaries. Additionally, R.I.G.L. § 27-18.8-3 Certification of Network Plans and 230-RICR-20-30-9.7 (A) (1) further direct carriers to monitor each of their separate network plans to assess whether or not each network plan's contracted providers are sufficient in scope and volume to meet the needs of its population (including children, adults and low-income, medically underserved beneficiaries, children and adults with serious chronic and/or complex health conditions or physical and/or mental disabilities and persons with limited English proficiency) in terms of accessibility to covered services in a timely manner and other providers sufficient to provide coverage in a timely manner of the benefits covered in the network plan and in a manner to assure that all covered services will be accessible without unreasonable delay. These statutory and regulatory requirements obligate carriers to maintain an accessible network of contracted providers in a manner sufficient to prevent beneficiaries from experiencing unreasonable delays in obtaining needed services. A carrier's failure to maintain an adequate network of providers results either in its beneficiaries seeking services outside of that carrier's contracted network which, in turn, results in additional financial burdens for beneficiaries, delays in obtaining needed health care services, or in beneficiaries not obtaining needed health care services at all.

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E. Network Adequacy for Urgent and Emergent Services. Pursuant to R.I.G.L. § 27-18-8-2 (10) and 230-RICR-20-30-9.3 (A) (12) “emergency services” means those resources provided in the event of the sudden onset of a medical, behavioral health, or other health condition that the absence of immediate medical attention could reasonably be expected, by a prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily organ or part. Furthermore, 230-RICR-20-30-9.7 (A)(2) requires that a carrier provide its beneficiaries immediate access to “emergency services” twenty-four hours a day seven days per week. Pursuant to R.I.G.L. § 27-18.9-2 (36) and 230-RICR-20-30-14.3 (39) “urgent health care services” are defined as those resources necessary to treat a symptomatic medical, mental health, substance use, or other health care condition that a prudent layperson, acting reasonably, would believe necessitates treatment within a twenty-four hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. Given these statutory and regulatory definitions, an adequate network must make emergency services available to its beneficiaries immediately and urgent services available to its beneficiaries within twenty-four hours. Failure to provide sufficient in-network (INN) provider access to emergency and urgent services would adversely affect the safety and welfare of beneficiaries and increase

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beneficiaries' financial obligations for these out-of-network (OON) emergency and urgent services.

- F. Quarterly Network Monitoring. A carrier is required to have ongoing processes that monitor the adequacy of its networks for its population of beneficiaries on at least a quarterly basis, as set forth in R.I.G.L. § 27-18.8-3 (c) (2) and 230-RICR-20-30-9.7 (B), with the latter further requiring that such processes be made available to OHIC for review. Therefore, a carrier must monitor its networks in a proactive manner in order to minimize and resolve any deficiencies that limit a beneficiary's ability to access covered services in a timely manner.
- G. Maintenance of Accurate and Complete Provider Directories. A carrier is obligated to maintain its Provider Directories, as set forth in R.I.G.L. § 27-18.8-3 (c) (4) (i)-(iv) and 230-RICR-20-30-9.7 (D) (2) which require the carrier to make its directories easily accessible to consumers and providers in an accurate, understandable and reasonably comprehensive format. Further, Regulation 230-RICR-20-30-9.7 (D) (4) stipulates that electronic and paper Provider Directories must be updated at least monthly and that daily updates must be available telephonically. Minor changes to provider information, to include address changes and a provider's tax identification number (TIN), must be made within seven business days in accordance with R.I.G.L. §27-18-83 (b) and 230-RICR-20-30-9.8 (A) (3) (b). Compliance with these provisions ensure that relevant Provider Directory information is up to date so as not to

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negatively impact a beneficiary's access to covered health care services.

If a Provider Directory is not updated in a timely manner, beneficiaries may not be able to reasonably determine, contact and/or effectively seek out INN providers, thereby resulting in potential delays in accessing care and additional financial burdens if a beneficiary unknowingly obtains health care services from an OON provider.

Additionally, 230-RICR-20-30-9.7 (D) (2) (c) (3) mandates that all Provider Directory formats include key professional provider information including hospital admitting privileges (if applicable) or providers' affiliations with INN facilities. Clear, complete, and accurate information regarding a professional provider's facility admitting privileges is essential to: accessing covered INN services in a timely manner; guarding against beneficiaries unknowingly obtaining services at an OON facility; guarding against beneficiaries unknowingly obtaining services from an OON professional provider at an INN facility; and protecting the beneficiary from significant financial burden if services are rendered OON.

- H. Credentialing and Re-credentialing. R.I.G.L. § 27-18-83 and 230-RICR-20-30-9.8 set forth carrier requirements for credentialing and re-credentialing professional providers. R.I.G.L. § 27-18-83 (a) and 230-RICR-20-30-9.8 (A) (3) (a) require a carrier to issue its decisions regarding the credentialing or re-credentialing of a professional provider as soon as it is practicable, but no later than forty-five (45) calendar days after the date of receipt of a completed credentialing application. Further, 230-RICR-20-30-

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9.8 (D) sets forth that credentialing and re-credentialing applications be considered complete when all the requirements listed in 230-RICR-20-30-9.8 (D) (1–8) have been submitted. Conversely, this regulation makes clear that a carrier may not require the submission of additional material beyond these eight items for an application to be considered complete unless such additional requirements are approved by the Commissioner. In accordance with 230-RICR-20-30-9.8 (A) (5), carriers are also required to provide each applicant with an update on the status of their credentialing or re-credentialing application at least once every 15 days informing them of any missing information. Non-compliance with these credentialing requirements causes delays in credentialing, contracting and re-credentialing and could negatively affect: a beneficiary's ability to timely access necessary covered services; a professional provider's ability to be reimbursed for covered services; and the carrier's ability to maintain an adequate network and an accurate Provider Directory.

- I. Carrier Obligation to Cooperate with Examination. Pursuant to R.I.G.L. § 27-13.1-1 et seq. (Examination Act) and R.I.G.L. § 27-18.8-8 (b) (3), carriers have an obligation to facilitate and reasonably cooperate in an examination conducted by OHIC. In particular, R.I.G.L. § 27-13.1-4 (b) requires that "The officers, directors, employees, and agents of the company or person must facilitate the examination and aid in the examination so far as it is in their power to do so." Failure to do so

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impedes the Examiners ability to effectively conduct Market Conduct Examinations.

3. Examination methodology and process

- A. In conducting the Examination, the Examiners observed those guidelines and procedures set forth in the National Association of Insurance Commissioners Market Regulation Handbook (“Handbook”) and other appropriate guidelines and procedures that the Commissioner deemed appropriate.
- B. The Examination targeted two areas of regulatory compliance (more detail is provided in the Information Data Request (IDR) documents which appear as items 1-26 in Appendix A), specifically:
 - i. Compliance with state Provider Directory laws and regulations, with a particular focus on:
 - a. The accuracy of the carrier’s Provider Directories;
 - b. Carrier maintenance of its Provider Directories for all network offerings;
 - c. Carrier policies and procedures for updating and managing its Provider Directories;
 - d. Carrier’s internal and external audit and compliance policies and processes;
 - e. Review of carrier’s process to assess the accuracy of its paper and electronic Provider Directories;

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- f. Beneficiary and provider communications regarding Provider Directories; and
 - g. Review of carrier complaint logs.
 - ii. Compliance with state Network Adequacy laws and regulations, with a particular focus on:
 - a. The carrier's policies, procedures, criteria, and selection standards regarding the admission of providers to the carrier's provider network;
 - b. The carrier's provider credentialing/re-credentialing policies and procedures for each type of professional provider within the plan network (e.g., medical, surgical, and behavioral health);
 - c. The carrier's provider credentialing/re-credentialing activities;
 - d. Carrier policies, procedures, and processes that audit, monitor and ensure that its provider network for each of its network plans (and network tiers, if applicable) are sufficient in scope and in volume;
 - e. Carrier's policies and procedures used to assess and monitor that it is meeting its population needs for all covered services and that these services are accessible to beneficiaries in a timely manner without unreasonable delay;
 - f. Review of approved and denied INN and OON claims data for any inadequacy in the carrier's network;

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- g. The carrier's ability to demonstrate that network plan beneficiaries have access to an OON provider in the event the plan fails to maintain sufficient provider contracts or when an INN provider is not available to provide covered services in a timely manner; and
- h. Review of carrier complaints logs.

C. Claims data submitted by Blue Cross in response to IDRs 17 and 18 were analyzed using Microsoft Power BI, which allowed Examiners to combine the submitted claims files into a unified data model. Summary tables were then exported to Microsoft Excel, so the Examiners could further analyze Network Adequacy, as detailed in Appendix B. Appendix B also details the methodology used to develop the following three categories of claims and data tables:

- i. Professional Service Claims using Procedure Codes (Professional Tables 1 and 2 in Appendix C);
- ii. Facility Claims using Procedure Codes (Facility Tables 1 and 2 in Appendix D); and
- iii. Facility Claims using Revenue Codes (Revenue Tables 1 and 2 in Appendix E).

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Findings, Conclusions, and Recommendations

4. In the course of reviewing the Blue Cross complaints and Blue Cross Complaint Processes for the purpose of assessing the adequacy of Blue Cross's network and the accuracy of its Provider Directories the Examiners discovered compliance failures in the Complaint Processes. These failures compromised the value of this source of examination data, negatively impacting the Examiners' ability to assess Network Adequacy and Provider Directory accuracy.

Complaint Findings and Conclusions

5. The Examiners reviewed Blue Cross's Complaint Processes and Complaint Logs⁶, which were submitted in response to IDR 10, in order to determine if there were any Provider Directory and Network Adequacy issues that may have been expressed in these complaints and to identify Blue Cross's responses to Provider Directory and Network Adequacy issues. This review led the Examiners to assess whether Blue Cross's Complaint Processes were compliant with Rhode Island law. The Examiners findings and conclusions are as presented in Paras. 6-14 herein.
6. In response to IDR 10.3 Blue Cross submitted its beneficiary and provider complaint policies titled "GA 7.01 Member Complaints (Commercial and Market Place Plans)" and "GA 7.01.01 Provider Administrative Complaint." These Blue Cross policies define an "inquiry" as "an oral or written request by a member or provider for BCBSRI to provide additional information regarding covered benefits, BCBSRI procedures, participating providers, the status of a claim or any other

⁶ References to Blue Cross Complaint Logs in this report refer to the documents submitted by Blue Cross in response to IDR10 entitled "ATT IDR 10-Supp_Grievance and Appeals Log".

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question regarding BCBSRI and its policies" and a "complaint" as "an oral or a written expression of dissatisfaction to review an actual or alleged circumstance which gives the member or provider cause for protest, including but not limited to dissatisfaction with a benefit or coverage decision, customer service, or the quality or availability of a health service." Blue Cross's complaint definition is narrower in scope than the required statutory and regulatory definition of complaint, specifically: "an oral or written expression of dissatisfaction by a beneficiary, authorized representative, or provider." R.I.G.L. § 27-18.8-2 (8) and 230-RICR-20-30-9.3 (A)(9). Limiting the scope of its definition of "complaint" results in Blue Cross's failure to accurately log and report all complaints. This ensuing underreporting of complaints prevented the Examiners' ability to accurately assess the total volume of complaints related to Network Adequacy and Provider Directory issues. In addition, by not properly identifying and categorizing all complaints, Blue Cross does not evidence that it fully processes all oral and written expressions of dissatisfaction according to state statutes and regulations.

7. In response to question #2 in IDR 10.3 regarding when an inquiry is escalated to a complaint, Blue Cross stated that if a member or provider contacts the Blue Cross Call Center an attempt is made to resolve the issue over the telephone and if the issue is resolved easily, it is logged as an inquiry and not a complaint. Blue Cross also responded that if the issue cannot be easily resolved and all resources have been exhausted trying to resolve the issue, it is then escalated to Customer and Provider Research. If the issue still cannot be resolved, the Complaint Process is then offered by Blue Cross to the member or provider. If at any time the member or

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provider specifically asks to file a complaint or sends a letter of complaint, the complaint is forwarded to the Grievance and Appeal Unit for the processing of the complaint. Based on these responses, Blue Cross is not identifying what of its "inquiry" category of communications are actually "complaints" and, instead, only categorizes complaints as such after various attempts to expeditiously resolve the issue has failed or when the complaint process is explicitly requested. Accordingly, Blue Cross does not process or log communications as complaints when such communications meet the regulatory or statutory definition of complaint.

8. **Conclusions of Law.** As presented in findings noted in Para. 6 and 7, Blue Cross did not define its "complaints" in accordance with the definitions set forth in R.I.G.L. § 27-18.8-2 (8) and 230-RICR-20-30-9.3 (A)(9) and instead utilized a definition of "complaints" that was significantly narrower in scope. Failure to define, categorize, and report all complaints results in underreporting to OHIC and OHIC's subsequent inability to determine Blue Cross's compliance with the required processing of complaints as set forth in 230-RICR-20-30-9.6 A 1-4. In addition, the Examiners were unable to accurately determine the level of member and provider Network Adequacy and/or Provider Directory concerns due to the underreporting of complaints by Blue Cross.
9. In response to IDR 10, Blue Cross submitted its Complaint Log for the Exam Period. The Examiners compared all 128 complaint files listed on the Blue Cross log to the internal complaint logs maintained by OHIC noting that all complaints received by OHIC are forwarded to the appropriate Carriers for resolution. Blue Cross is required to include all complaints received in its complaint logs. Thus,

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Blue Cross is required to include all complaints forwarded to it by OHIC in its complaint logs. OHIC forwarded five complaints to Blue Cross for processing during the Exam Period. None of these five forwarded complaints, as identified by the following OHIC tracking numbers, were contained in Blue Cross's Complaint Log (Appendix F):

- A. 54815 applied behavioral analysis services;
- B. 54817 coordination of benefits;
- C. 54816 credentialing issue;
- D. 54927 provider payment and coordination of benefits; and
- E. 55016 claim denial.

10. Conclusions of Law. Based on the findings in Para. 9 Blue Cross does not accurately log and monitor all of its complaints, nor does it report all of its complaints to OHIC as required by R.I.G.L. §27-18.8-6, 230-RICR-20-30-9.6 (A)(4), and 230-RICR-20-30-9.10 (A). Blue Cross's failure to log and report complaints sent to it by OHIC for processing evidenced a lack of accurate logging and reporting of all complaints. Given the findings in Para. 9 and the reasonable expectation that complaints are received by Blue Cross through a variety of entry points, the Examiners do not have confidence that all complaints received by Blue Cross, regardless of entry point, are properly logged by Blue Cross thus resulting in underreporting and a failure to track all complaints.

11. The Examiners reviewed the Complaint Log descriptions of all 128 listed complaints in the Complaint Log submitted by Blue Cross in IDR 10 and identified 18 complaints that were related to Provider Directory or Network Adequacy issues.

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The Examiners then requested Blue Cross's complete case files for each of these 18 complaints and reviewed the contents of the case files provided by Blue Cross. The Examiners found that in four of these 18 complaints Blue Cross did not provide adequate documentation to substantiate that it resolved the complaint. In these four files, Blue Cross did not adequately document the process by which the complaints were resolved, as neither Blue Cross's documentation nor its responses provided to the complainants addressed the concerns stated in these complaints. Details are as follows:

- A. In Case File 01414978 Blue Cross did not document adequate assistance to place the complainant's child with a provider
- B. In case 01478697 Blue Cross did not address the complainant's concerns regarding the availability of primary care providers and did not document any assistance that placed the complainant with an INN primary care provider;
- C. In Case File 01506853 Blue Cross did not document any assistance to place the complainant with an INN primary care provider; and
- D. Case File 01513069 Blue Cross did not document a reasonably adequate resolution of this complaint, including a clear determination of whether the services could be provided INN or whether an OON request would be necessary and appropriate.

The Examiners did not request and did not review the complaint files associated with the remaining complaints listed on the Complaint Log that purported to be unrelated to Network Adequacy and Provider Directories.

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The Examiner's note a concern that a review of these remaining complaint files would reveal additional cases where Blue Cross did not evidence resolution of these complaints.

12. **Conclusions of Law.** Based on the findings in Para. 11, Blue Cross did not fully resolve and/or adequately document the resolution of all its complaints according to the requirements set forth in R.I.G.L. § 27-18.8-3 (b)(4) as well as 230-RICR-20-30-9.6 (A)(1). Based on the complaint information provided by Blue Cross, the Examiners were unable to confirm that all complaints are fully reviewed and resolved.

13. The Examiners reviewed Blue Cross's Complaint Logs, complaint policies, procedures, and processes as well as its auditing and oversight of Network Adequacy and its oversight of the accuracy of its Provider Directories. The Examiner's found no evidence that Blue Cross used beneficiary and provider Network Adequacy and Provider Directory related complaints to inform its assessment and oversight of the adequacy of its networks or the accuracy of its directories.

14. **Conclusions of Law.** Based on the findings in Para.13 the Examiners concluded that Blue Cross did not use beneficiary and provider Network Adequacy and Provider Directory related complaints in its oversight efforts to ensure Network Adequacy and accuracy of its Provider Directory in violation of the 230-RICR-20-30-9.6 (B) (2) and 230-RICR-20-30-9.6 (E). These rules require that Blue Cross maintain a process that ensures that issues brought to the attention of Blue Cross regarding its network plans via its Complaint Processes are regularly considered

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and addressed by Blue Cross in the context of developing, reviewing and evaluating the adequacy of its networks and the accuracy of its Provider Directory.

Complaint Recommendations

15. Blue Cross shall implement the following recommendations in order to remediate the non-compliant practices found by the Examiners and described in Paras. 6-14. Within sixty days from the date the consent order is signed by both parties, Blue Cross shall implement each of the following Complaint Recommendations set forth in Paras. 16-19.
16. Blue Cross shall establish revised policies and procedures to identify, manage and process its complaints establishing the following:
- A. Revision of its definition of “complaint” to comply with R.I.G.L. § 27-18.8-2 (8) and 230-RICR-20-30-9.3 (A)(9);
 - B. The accurate logging, processing, and reporting of all complaints shall be defined and processed in accordance with 230-RICR-20-30-9.3 (A)(9) and 230-RICR-20-30-9.6 (A)(1) and (4). This shall include a procedure to ensure that complaints are accurately categorized as complaints and that the processing of complaints includes documentation of the complaint resolution.
 - C. Revise processes to ensure that complaints received from different areas in and outside of Blue Cross (e.g., Consumer and Provider Service Representatives, Customer and Provider Research staff and Complaint and Grievance staff, RIREACH, OHIC, and other state and federal

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agencies) are properly categorized and logged as complaints in a central complaint database and reported to OHIC.

17. Blue Cross shall create a training manual and a training process for Consumer and Provider Service Representatives, Customer and Provider Research staff, Complaint and Grievance staff, and any other staff that are in receipt and/or manage complaints. This training shall include the implementation of the revised policies and procedures noted in Para. 16. Blue Cross shall provide such training upon any revision of policies and procedures and on a periodic basis no less than annually.
18. Blue Cross shall establish an audit process to periodically monitor the activity of its Consumer and Provider Service Representatives, Customer and Provider Research staff and Complaint and Grievance staff to ensure compliance with its revised complaint policies and procedures.
19. Blue Cross shall prepare and submit a report to OHIC, by October 31, 2022, which shall identify and summarize all complaints received relating to Network Adequacy and Provider Directory issues during the time period of March 1, 2022 through August 31, 2022. This report shall further convey how Blue Cross incorporated complaint information into its periodic monitoring and assessment of its Network Adequacy and Provider Directory accuracy.

Provider Directory Findings and Conclusions

20. The Examiners reviewed Blue Cross's responses to the IDR's identified in the below paragraphs (the specifics of each IDR request and response, including

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follow-up requests and responses, can be found in Appendix A) as well as the interviews conducted with Blue Cross staff. The Examiners' findings and conclusions are set forth in in Paras. 21-29.

21. Blue Cross's response to IDR 6 which requested information about procedures for updating Provider Directories, included a document titled "ATT IDR 6-CN_ 4.03_ Changes_ to_ the_ Provider_ Database.pdf" that states, "The provider databases are updated within seven business days of receipt." During the Interview, Blue Cross staff noted that once Blue Cross receives Provider Directory updates, these changes are not visible to consumers via the online Provider Directory (Online Provider Directory, also referred to herein as the "Find a Doctor" tool at www.bcbsri.com) until the following Tuesday, when a third-party vendor uploads those changes to the "Find a Doctor" portal. The Examiners therefore found that Blue Cross did not maintain daily accurate updates to its online "Find a Doctor" Provider Directory.

22. IDR 26 requested additional information regarding procedures and processing timelines for updating Provider Directories. Blue Cross's response to IDR 26 included the following response: "Provider Demographics completes updates received from practitioners, facilities and various notification sources within seven business days of receipt of new information. The BCBSRI Vendor for Provider Database Management, Perspective sends the online directory vendor, Healthsparq, directory data* product information on a weekly basis to update the online Provider Directory. The participating practitioner/provider/hospital network information found on the Corporate Website is updated by Healthsparq on a

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weekly basis, thus ensuring all updates are made to the online physician and hospital directories within 30 calendar days of receipt of new information”.

23. The Blue Cross response to IDR 26 also provided the following example timeline:

“If an existing provider requests a change on January 1, 2020, the request would be received by the Provider Database group on January 1, 2020, added to Facets by or before January 10, 2020, and available for viewing on the “Find a Doctor” tool on bcbsri.com by January 14, 2020.” As a follow-up to IDR 26, confirmation was requested by the Examiners as to what database was used by Blue Cross staff to respond to telephonic requests from members for Provider Directory information. Blue Cross responded in an email dated July 21, 2020 that Blue Cross staff uses the online “Find a Doctor” tool at www.bcbsri.com. In other words, Blue Cross answered that its staff uses the online “Find a Doctor” Provider Directory to respond to telephonic requests for Provider Directory information. Blue Cross thereby does not have daily updates to its Provider Directories available telephonically and, on average, updates to its online Provider Directory are greater than seven days.

24. Conclusions of Law. Based on the findings in Paras. 21-23, Blue Cross is in violation of R.I.G.L. § 27-18.8-3 (c)(4) and 230-RICR-20-30-9.7 (D)(4) as it does not make daily Provider Directory updates available telephonically to beneficiaries and providers. Failure to make available daily telephonic updates to its Provider Directories negatively impacts Blue Cross's beneficiaries' ability to access a full network of providers or to access its provider network in a timely manner.

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25. In response to IDR 3.1 Blue Cross provided electronic copies of its paper directories. These paper directories did not include provider data regarding hospital admitting privileges as required. After further questioning, Blue Cross responded to IDR 3.1.1, acknowledging that paper directories could not currently be provided in a manner or format that contains hospital admittance privileges for providers. Blue Cross's response states: "While a provider's admitting privileges is included in the online "Find a Doctor" tool on the bcbsri.com website, the process to print provider directories currently does not have the function to include the admitting privileges data." Blue Cross did state that it is in the process of evaluating and adding this function for customers who request a paper Provider Directory.

26. Conclusions of Law. Based on the findings in Para. 25, Blue Cross is in violation of R.I.G.L. § 27-18.8-3 (c)(4)(iii) and 230-RICR-20-30-9.7 (D)(2)(c)(3) as it does not include in its production of paper Provider Directories hospital admitting privilege information or affiliation information that notes whether those facilities are in the Blue Cross network. For those utilizing paper directories, not having this key provider information could lead to a beneficiary unknowingly obtaining services at an OON facility and subsequently incurring additional financial responsibility.

27. Blue Cross conducted monthly "Secret Shopper" audits and submitted documentation of the results of these audits in response to IDR 7.1. These monthly audit results are found in attachments submitted by Blue Cross titled "ATT IDR 7.1-1_Secret Shopper 1 2019" and "ATT IDR 7.1-2_Secret Shopper 2 2019". The monthly audits reveal that Blue Cross contacted 850 professional providers over an 11-month period (January 2019 through November 2019) to evaluate the

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accuracy of the information found in its Provider Directory. The accuracy of the directories ranged from 38%-84%, depending upon the audit category. Conversely, the error rate for the accuracy of the directories ranged from 16%-62% depending on the audit category. The audit categories included: hospital affiliations, whether or not a provider was taking new patients, telephone number no longer in service, incorrect telephone and fax numbers, providers no longer at a particular practice, providers who had retired, and incorrect addresses.

28. Additionally, the Examiners reviewed the information submitted by Blue Cross in response to IDR 7.0, 7.1, 7.2 and 7.4 that requested its procedures and controls for validating the information contained in its Provider Directory. The Examiners did not find evidence that Blue Cross initiated a follow-up process during the Exam Period to decrease the repeated errors it identified in the Secret Shopper audits noted in Para. 27.

29. Conclusions of Law. Based on the findings in Para. 27 and 28, Blue Cross is in violation of R.I.G.L. § 27-18.8-3 (b), 230-RICR-20-30-9.6 (E), and 230-RICR-20-30-9.7 (D)(2) as Blue Cross did not provide evidence of effective oversight of its Provider Directory accuracy in that it did not conduct timely follow up on its Secret Shopper audits to remedy repeated Provider Directory errors occurring during the Exam Period.

Provider Directory Recommendations

30. Blue Cross shall implement the following recommendations in order to remediate the non-compliant practices found by the Examiners and as described in Paras.

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21-29. Within sixty days from the date the consent order is signed by both parties, Blue Cross shall implement each of the following Provider Directory Recommendations set forth in Paras. 31-34.

31. Blue Cross shall establish revised policies, procedures, and processes to include:

- A. Consistent and compliant timelines for the accurate updating of electronic, paper, and telephonic Provider Directory including, without limitation, a Provider Directory database capable of supporting the requirement that accurate daily updates be made available telephonically.
- B. Policies to ensure that employees responsible for responding to telephonic inquiries for Provider Directory information have access to and utilize a database that is accurately updated daily.
- C. A mechanism to include the status of a provider's hospital admitting privileges (if applicable) and affiliations with INN facilities in its paper Provider Directories; and
- D. A revised process for effectively auditing the accuracy of its Provider Directories and correcting identified deficiencies. This process shall include at a minimum: periodic direct communication with network providers to audit and ensure directory accuracy; auditing of a comprehensive number of providers and provider types, to include BH providers; mechanisms for ensuring Provider Directory accuracy across all provider types; the systematic use of data-driven information (e.g., claims, complaints, inquiry logs, credentialing, contracting) to inform and evaluate directory accuracy and compliance. This process shall also include

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mechanisms to correct identified deficiencies, improve upon directory error rates and document said corrections and improvements.

32. Blue Cross shall create a training manual and a training process that includes the revised policies and procedures noted in Para. 31 and provide necessary ongoing training for staff whenever policies and procedures are revised and on a periodic basis no less than annually.
33. Within six months from the date the consent order is signed by both parties, Blue Cross shall conduct a Provider Directory audit, in accordance with Para. 31 D and provide OHIC with the report summarizing and certifying that this audit was conducted in accordance with Para. 31 D as well as setting forth the results of the audit and the Carrier's plans for addressing any identified deficiencies revealed by the audit.
34. Within six months from the date the consent order is signed by both parties, Blue Cross shall submit to the Commissioner, for approval, a plan for a master data management solution that consolidates disparate provider information received by Blue Cross and enables Blue Cross to create a single, accurate, up-to-date source of network provider information.

Network Adequacy Findings and Conclusions

35. The Examiners reviewed Blue Cross's responses to the IDR's identified in the below paragraphs (the specifics of each IDR request and response, including follow-up requests and responses, can be found in Appendix A) as well as the

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interviews conducted with Blue Cross staff. The Examiners' findings and conclusions are set forth in Paras. 36-61.

36. From a review of Blue Cross's responses to IDR 12 and Interviews with staff, the Examiners found that Blue Cross did not have a quarterly review policy in place to monitor the adequacy of each of its network plans for the entire Exam Period. Blue Cross submitted a policy in response to IDR 12.1 titled "ATT IDR 12-2_CN_3.06_Monitoring and Management of Network Availability-REDLINED" which documents that its annual monitoring policy was in place from August 6, 2019 to the end of the Exam Period. In a follow-up response to IDR 12.1 Blue Cross stated that this policy was updated on December 5, 2019, changing the analysis of network capabilities back to quarterly.
37. In response to follow-up IDR 12.1.2 requesting confirmation that network adequacy reviews were performed on a quarterly basis during the Exam Period, Blue Cross stated that it had only performed a quarterly review in the second and fourth quarters of 2019 and had not performed a quarterly review in the first or third quarters of 2019. Consequently, Blue Cross acknowledged it only performed one quarterly review during the eight-month Exam Period.⁷ When the Examiners requested documentation of the two quarterly Network Adequacy reviews Blue

⁷ More specifically, Blue Cross provided the following response:

Blue Cross & Blue Shield of Rhode Island ("BCBSRI") performed network adequacy reviews in the second (see Attachment IDR 15-1) and fourth quarters of 2019 through its GeoAccess Practitioner Availability Analysis. BCBSRI did not perform a GeoAccess Practitioner Availability Analysis in the first or third quarters of 2019; however, BCBSRI experienced no changes to its provider network that would have triggered an ad hoc review, and there were no issues identified within the Essential Community Provider ("ECP") and Network Adequacy template or Quality Health Plan ("QHP") ECP tool performed in the third quarter of 2019 (see Attachment IDR 15-2 and Attachment IDR 15-3). In 2020, BCBSRI plans to perform the GeoAccess Practitioner Availability Analysis on a quarterly basis.

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Cross stated it performed, Blue Cross could only provide, and thereby substantiate, the review performed in May of 2019 (see IDR 15.4).

38. Conclusion of Law. Based on the findings in Paras. 36 and 37, Blue Cross is in violation of R.I.G.L. § 27-18.8-3 (c) (2) and 230-RICR-20-30-9.7(B) by: (a) not monitoring the status of each of its networks at least quarterly, (b) failing to maintain a policy and practice requiring quarterly monitoring of each of its networks, and (c) failing to maintain documentation of stated “quarterly” network adequacy reviews in a manner to enable substantiation of this process to OHIC upon request. Quarterly network adequacy review requirements are designed to assist Carriers and OHIC in identifying network inadequacies in a timely manner so as to meet the needs of beneficiaries on a continuous basis.

39. The Examiners reviewed Blue Cross’s responses to IDR 11 requesting policies, procedure and standards used by Blue Cross to admit providers to its networks. This response included a document titled “ATT IDR 11-2__CN 3.03.05 Ancillary Non-Professional Network Closure Policy and Procedure.pdf” that states as of “August 31, 2010, BCBSRI’s Initiatives Steering Committee (ISC) accepted the recommendation of Network Management to close all Ancillary Non-Professional Provider Networks.” All BH facilities were placed on this closed network list, together with a subset of M/S non-professional providers and were then subject to additional review and approval processes in order to be considered for inclusion in Blue Cross’s network. An additional attachment was provided in this IDR 11 response labeled “ATT IDR 11-3__BH Facility Contracting Departmental Procedure 04.2019.pdf” that describes these additional credentialing and contracting

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requirements for BH facility providers who wish to contract with and be included in Blue Cross's network. Among many other additional requirements for participation presented in this attachment, a financial and cost impact analysis, the assessment of program utilization and the facilities' average length of stays are examined by Blue Cross prior to accepting BH facilities into its network. Attachment "ATT IDR 11-3_BH Facility Contracting Departmental Procedure 04.2019.pdf" further states that the additional information and data collected from BH facilities is then submitted to Blue Cross "Analytics" for review and approval. Blue Cross provided supplemental information indicating that the requirements set forth in this attachment were not applied in practice to BH facilities.

40. Conclusions of Law and Statement of Concern. Based on findings in Para. 39, Blue Cross is in violation of 230-RICR-20-30-9.6 (E), as it did not maintain policies and procedures that accurately reflected its practices. The Examiners also note their concern that the policy documents referenced in Para. 39 appear to indicate a different set of standards and/or requirements for BH facilities though there is no evidence that Blue Cross implemented such standards.
41. In IDR 16, the Examiners requested documentation of Blue Cross's approach and methodology in determining the adequacy of its provider network including network tiers to include measurements, parameters, goals, and identified network gaps. Blue Cross responded with the submission of a document titled "ATT IDR 15-8_QM 3.02 Development and Evaluation of Member Access Standards for Office Care" (hereinafter "Access Standards"). Page 4 of this document describes Access

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Standards for prescribing and non-prescribing BH providers.⁸ In these Access Standards Blue Cross requires access for beneficiaries seeking routine BH care⁹ from a BH network provider who is a “Non-Prescriber” to be within 30 days and from a BH network provider who is a “Prescriber” it is within 90 days. For an initial routine BH care visits from either a “Non-Prescriber” or a “Prescriber” the Access Standard is set at within 10 business days. In contrast, primary care and M/S specialists non-urgent symptomatic care¹⁰ the Access Standard is within 14 days and for new patients that standard is within 30 days. For primary care preventive/routine care¹¹ the standard is within 2 months. There is no “prescribing” distinction in Blue Cross’s M/S network providers’ Access Standards.

42. The Examiners also found on page 4 of the document titled “ATT IDR 15-8_QM 3.02 Development and Evaluation of Member Access Standards for Office Care” in Blue Cross’s response to IDR 16 that Blue Cross Access Standards for emergency services with BH providers were different than those set for M/S providers. Blue Cross distinguishes between its BH “Emergency care”¹² services and BH “Non-Life-Threatening Emergency”¹³ services, but there is no such distinction for M/S emergency services. Access Standards set forth by Blue Cross for M/S

⁸ Blue Cross defines prescribing BH providers to “include Psychiatrists, Clinical Nurse Specialists and Psychiatric Nurse Practitioners” and non-prescribing providers to “include License Independent Clinical Social Workers Psychologists, Licenses Marriage & Family Therapists and Licensed Mental Health Counselors.”

⁹ Routine Care Appointment for BH care is scheduled office visits for any BH concern which is of a non-emergent or non-urgent nature.

¹⁰ Non-Urgent, Symptomatic primary and M/S specialty care is defined as any symptomatic medical condition or illness that is non-emergent or non-urgent.

¹¹ Preventive/Routine Care for primary care are annual assessments as well as routine physical exams and care.

¹² BH “Emergency care” is defined by Blue Cross as “A sudden or unexpected behavioral health condition that is life threatening and requires immediate psychiatric treatment to prevent death or disability to the patient or others.”

¹³ BH “Non-Life threatening Emergency” is defined by Blue Cross as “Symptoms of behavioral health problems that require prompt attention but are not immediately life-threatening to patient or others.”

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"Emergency care"¹⁴ requires the beneficiary to have immediate access to M/S emergency services regardless of whether those emergency services are in response to life threatening or non-life-threatening emergencies. On the other hand, Blue Cross sets its Access Standards for beneficiaries seeking access to BH "Non-life-threatening Emergency" care at within six hours.

43. Statement of Concern. Based on the findings in Paras. 41 and 42, Blue Cross's Access Standard definitions used for BH emergency care are not consistent with the definitions set forth in R.I.G.L. §27-18.8-2 (10), 230-RICR-20-30-9.7(A)(2) and 230-RICR-20-30-9.3(A)(12)¹⁵. Although Blue Cross generally categorizes BH Prescribers as specialty care providers in its policy documentation, the Examiners note their concern that the access standards for these BH specialty care providers are different from the access standards for other M/S specialty care providers.
44. In addition to the responses to IDR 16 in Paras. 41 and 42, Examiners requested documentation of Blue Cross's approach and methodology in determining the adequacy of its provider network and Blue Cross submitted a document titled "ATT IDR 15-1 GeoAccess Practitioner Availability Analysis" (hereinafter "GeoAccess") revealing both its GeoAccess standards as well as its analysis of Blue Cross's network in meeting these standards. The Blue Cross GeoAccess standards utilize provider-to-member ratios and numbers of providers within a distance radius of the members residence. In this document Blue Cross also sets forth the provider types

¹⁴ MS "Emergency care" is defined by Blue Cross as "An illness or condition that without immediate treatment, could result in placing the members life or general health in severe jeopardy."

¹⁵ The Examiners note that Blue Cross evidenced to the satisfaction of the Examiners that its definition of Non-life-threatening emergency is equivalent to Rhode Island's definition of urgent healthcare services as defined in R.I.G.L. 27-18.9-2 (36).

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it selected to include in its GeoAccess reports assessing M/S Network Adequacy.

The primary care practitioners (PCP) selected were Family Practice, Internal Medicine, Pediatrics Primary, Nurse Practitioner or PA; for high volume M/S specialty care providers¹⁶ they were Allergy/Immunology, Dermatology, Ears, Nose & Throat (ENT), OB/GYN and Urology; and for high impact specialty care providers¹⁷ they were Oncology, Cardiology, Orthopedics and Gastroenterology. These same reports reflected an assessment of high volume BH providers¹⁸ and included, separately, prescribing and non-prescribing BH providers. Blue Cross's GeoAccess analysis indicated that Blue Cross selected fewer BH provider types to measure its BH Network Adequacy. Prescribing providers were psychiatrists, psychologists and nurse practitioners and non-prescribing BH providers were licensed clinical social workers, licensed marriage and family therapists and licensed mental health counselors. Access to facility providers was also examined, by Blue Cross assessing the numbers of facilities within a distance radius of the members residence, but included only hospitals, pharmacies and laboratories. Blue Cross's Network Adequacy processes do not adequately assess network access for its population of beneficiaries for all covered benefits, for example the

¹⁶ High Volume M/S Specialty (HVS) care providers were determined by Blue Cross using "claims volume reporting to determine which specialties concentrate the most member count. The five highest-volume specialties are considered HVS."

¹⁷ High impact specialty (HIS) providers were considered by Blue Cross as those "practitioners that treat conditions that have high mortality and morbidity rates, or where treatment requires significant resources. These are determined by evaluating claims volume, membership data, and medical expense trend data. The four high impact specialties selected by Blue Cross were oncology, cardiology, orthopedics, and gastroenterology

¹⁸ High volume BH (HVBH) care providers were determined by Blue Cross using "claims volume and those most likely to provide services to the largest segment of the membership." Blue Cross then divided these HVBH providers into two categories based on prescriptive privileges.

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Network Adequacy of the following services are not assessed by Blue Cross:

ambulatory services; rehabilitative and habilitative services and devices; maternity and newborn care; pediatric oral and vision care; and key BH service such as residential treatment, intensive outpatient, partial hospitalization and acute inpatient substance use detox. In response to the Examiners' questions around how Blue Cross analyzed and assessed the Network Adequacy of each of its networks and network tiers, Blue Cross stated, "The reports are not produced separately within each network and network tier."

The single Network Adequacy review and report dated May 2019 conducted by Blue Cross during the Exam Period and provided to the Examiners ("ATT IDR 15-1 GeoAccess Practitioner Availability Analysis") (a) did not provide evidence of an assessment of its beneficiaries' Network Adequacy needs for all covered services and (b) did not attempt to specifically assess the Network Adequacy of each of its networks.

45. Conclusion of Law. Based on the finding in Para. 44, Blue Cross did not have an adequate process in place to evaluate Network Adequacy to ensure that it has providers sufficient to cover its beneficiaries' needs, thereby violating R.I.G.L. §27-18.8-3 (c)(2) and 230-RICR-20-30-9.7 (A)(1). Included in Blue Cross's violation of 230-RICR-20-30-9.7 (A)(1) is its failure to assess and ensure that it has a network sufficient in scope and volume to deliver timely health care services to meet the needs of adults and children and those who are low income, are medically underserved, have serious chronic and/or complex medical conditions, have physical and BH disabilities, and have limited English proficiencies.

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46. Blue Cross's policies, procedures, flow charts, and data provided in its responses to IDRs 22, 23 and 23.2 indicate that Blue Cross utilizes and/or materially narrows its definition of a "complete application" in the context of the date by which a credentialing application is considered complete in a manner that conflicts with the statutory and regulatory definitions of a complete application. Blue Cross defines the date of a completed credentialing application as the date that it determines the application to not only be complete, in terms of information and documentation submitted, but also to be "clean", in terms of not presenting any areas of concern for Blue Cross, as noted on page 3 of a policy titled "ATT IDR 22-6_CR 2.01.02 Credentialing Recredentialing Approval Process". This definition and policy reflect that Blue Cross's determination of a completed application for purposes of triggering the statutory 45-day provider notification period is not based solely on receipt of required application information (i.e., R.I.G.L. § 27-18-83 (g)(1) a complete credentialing application). Rather Blue Cross' definition of a completed application is tied to the completion of a "clean" and verified credentialing application, which requires reviews and subjective assessments by Blue Cross of the information contained in these applications.
47. Page 2 of the red-lined policy document titled "ATT IDR 22-6_CR 2.01.02 Credentialing Recredentialing Approval Process" reflects Blue Cross's credentialing approval timelines in effect between 4/19/2018 through 4/19/2019 to include "All denied practitioners will receive written notification of denial reasons within 60 days of a completed and verified application or completed verification of re-credentialing." This policy document further states that Blue Cross's policy in effect between 4/8/19 through 4/9/2020 included "Determination is made on all professional providers' new, clean and

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complete applications within forty-five (45) days of receipt of an application. See Appendix CR A3. All re credentialing is completed within 180 days of initiated re credentialing. All denied practitioners will receive written notification of denial reasons within 45 days of a completed and verified application or completed verification of re credentialing". Blue Cross's policies to include its varying timelines for its credentialing application process failed to comply with the statutory requirement to communicate credentialing and re-credentialing decisions within 45-calendar days of receipt of a completed application.

48. In response to IDR 23 Blue Cross submitted its credentialing and recredentialing activity for the Exam Period. A total of 848 providers submitted credentialing applications, 844 were approved and four providers were denied during the Exam Period. As noted in Para. 46 Blue Cross's determination of the receipt of a completed application for purposes of triggering the statutory 45-day provider notification timeframe did not begin until the application was complete and verified. As a result, the Examiners found that, for 392 of the credentialing applications, Blue Cross failed to evidence that it complied with the 45-calendar day provider applicant decision notification for these 392 credentialing applications according to Rhode Island requirements.

49. Documentation of Blue Cross's recredentialing activity was also submitted in IDR 23. A total of 3812 provider recredentialing applications were processed, 3645 were approved and 167 denied. Blue Cross explains in this IDR response that it "...automatically re-credentials providers in a seamless manner and does not require providers to reapply." And, as a result of this "seamless" process, Blue Cross further clarifies that the "...receipt date of completed application or request' for many providers is marked as

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'N/A' on Attachment IDR 23." Finally, Blue Cross confirms in its IDR 23 response that "BCBSRI sends written notification only to providers who are denied re-credentialing...". Additionally, Blue Cross did not provide evidence that it communicated re-credentialing decisions within the required 45 calendar days of receipt of a completed application. Also, Blue Cross failed to evidence as part of this "seamless" re-credentialing process that it compliantly communicates with providers that they are in the process of being recredentialed. For those providers who are denied re-credentialing this "seamless" process creates a greater likelihood that they will continue to see patients after losing a credentialed status and subsequently places the beneficiary at greater financial risk. Furthermore, Blue Cross's responses indicated that no recertification application process outside of this "seamless" recredential process existed as an alternative option for providers.

50. Conclusions of Law. Based on the finding in Paras. 46– 49, Blue Cross narrowed the definition of completed application in a manner that violated R.I.G.L. §27-18-83 (g)(1), R.I.G.L. §27-18.8-3 (d) (2) (i), 230-RICR-20-30-9.8 (D)(1-8), and 230-RICR-20-30-9.8 (A) (3) (a). In using this non-compliant definition, Blue Cross failed to evidence that it adhered to the 45-calendar day notification requirements set forth in R.I.G.L. §27-18-83 (a) and 230-RICR-20-30-9.8(A) (3) (a) for 392 credentialing applications it processed during the Exam Period. Blue Cross, in using its "seamless" recredentialing process, failed to adhere to the statutory re-credentialing requirements including; (a) identifying the start date for the credentialing process in compliance with the receipt of a completed re-credentialing application in compliance with R.I.G.L. §27-18.8-3 (d) (2) (i); (b) adhering to the 45 calendar day notification requirements set forth in R.I.G.L. §27-18-83

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(a) and 230-RICR-20-30-9.8(A) (3) (a), for the recredentialing applications it processed during the Exam Period; (c) allowing for providers to submit completed applications pursuant to R.I.G.L. §27-18.8-3 (d) (2); (d) evidencing to the Examiners compliance with the provisions of regulation 230-RICR-20-30-9.8 (A) (3); and (e) evidencing a mechanism to assure effective communications with INN professional providers during the recredentialing process as required by 230-RICR-20-30-9.8 (A) (4). Blue Cross's variable policy language described in Para. 47 also failed to evidence compliance with the 45 calendar day notification requirements set forth in R.I.G.L. §27-18-83 (a) and 230-RICR-20-30-9.8(A) (3) (a).

51. The Examiners analyzed the claims data in Professional Table 1, Tab 2 (Appendix C). This table includes 49,505 professional procedure code claims with 20,332 (41.1%) of these claims identified as M/S and 29,173 (58.9%) identified as BH. Of the total professional procedure code claims analyzed, 6,166 (12.5%) were identified as OON, with 33% of the 6,166 identified as M/S OON claims and 67% as BH OON claims. After filtering the claims data submitted by Blue Cross (as described in Appendix B) and then analyzing the 49,505 professional procedure code claims subset detailed in Appendix C, the Examiners found that a larger proportion of the OON professional code claims were for BH services and that these OON BH service categories were across all BH service levels of care, whereas the M/S OON service categories were limited to Speech Therapy, Manipulation and Office Counseling and Consultation.
52. The Examiners further analyzed the claims identified in Para. 51 to determine what specific diagnostic categories were linked to these M/S and BH OON claims. Professional Table 2, Tab 2 provides more detail on the OON claims found in

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Professional Table 1, Tab 2 by filtering the data to only include diagnostic categories with at least 25 OON claims (more detail is provided in Appendix B). Upon review, the Examiners identified a similar pattern: there were disproportionately more OON claims for BH than M/S, as noted in Para. 51. Of the 31,938 professional procedure code claims analyzed in Professional Table 2, Tab 2, the Examiners identified 11,610 (36.4%) as M/S and 20,328 (63.6%) as BH. Of the total professional procedure codes analyzed in this table, 4,521 (14.2%) were identified as OON claims, 26.9% of which were M/S OON claims and 73.1% of which were BH OON. The Examiners then broke down these OON claims by diagnoses, which revealed that Speech Therapy and Chiropractic Manipulation services made up the largest proportion of M/S OON claims (55.3% and 32.6% respectively) for a variety of diagnoses, as detailed in Professional Table 2 in Appendix C. The Examiners also found that Individual Psychotherapy and Group Therapy made up the largest proportion of the OON BH claims (62.6% and 23.8% respectively) and were primarily for diagnoses of major depression, anxiety, adjustment disorders, and attention deficit hyperactivity disorders. See Professional Table 2 in Appendix C for additional information to support these findings.

53. Based on the data analysis of professional procedure code claims described in Paras. 51 and 52 and the additional data analysis detailed in Professional Tables 1 & 2 (Appendix C), the Examiners concluded that this claims data suggests professional provider network inadequacies for speech therapy, manipulative therapy, group psychotherapy and individual psychotherapy. The Examiners also found that there were a disproportionately higher number of professional provider services rendered OON for BH services and diagnoses than for M/S categories.

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54. The Examiners also analyzed the facility procedure code claims data in Facility Table 1, Tab 2 (Appendix D). This table shows a total of 26,988 facility procedure code claims with 10,202 (37.8%) of these facility procedure code claims identified as M/S claims and 16,786 (62.2%) identified as BH claims. Of the total facility procedure code claims analyzed, 7,128 (26.4%) were identified as OON, 22.7% of which were M/S OON claims and 77.3% of which were BH OON claims. After filtering the claims submitted by Blue Cross and analyzing the facility procedure code claims subset detailed in Appendix D, the Examiners found that a larger proportion of OON claims were for BH services and that OON BH services were across all facility service levels of care, whereas the M/S OON facility service categories were limited primarily to dialysis services and hospital outpatient clinic visits.

55. The Examiners further analyzed the facility procedure code claims identified in Para. 54 to determine what specific diagnostic categories were linked to these OON facility procedure code claims. Facility Table 2, Tab 3 filters the claims in Facility Table 1, Tab 2 by only including the diagnostic categories with at least 25 OON claims. The Examiners concluded that Facility Table 2, Tab 3 reveals a pattern similar to the one noted in Para. 54: a disproportionate number of OON facility procedure code claims were for BH compared to M/S. The total number of facility procedure code claims analyzed in Facility Table 2, Tab 3 was 18,214, with 8,388 (46.1%) of these claims identified as M/S and 9,826 (53.9%) identified as BH. Of the total facility procedure codes analyzed in this table, 6,285 (34.5%) were identified as OON claims, 20.5% of which were M/S OON and 79.5% of which were BH OON. A breakdown of the diagnoses associated with at least 25 or more OON M/S claims (Tab 3 facility

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procedure code filtered claims) revealed that dialysis services for end state renal disease was the only M/S category identified with 25 or more OON claims. A breakdown of the diagnoses associated with at least 25 or more OON B/H claims (Tab 3 facility procedure code filtered claims) revealed that substance use disorder diagnosis at outpatient, partial hospitalization, inpatient and residential levels of care made up 99% of these BH OON claims. See Facility Table 2 in Appendix D for additional information to support these findings.

56. Based on the data analysis in Paras. 54 and 55 and the additional data analysis detailed in Facility Tables 1 & 2, the Examiners found that the claims data suggests network inadequacies for dialysis services for end stage renal disease and for all levels of care for substance use disorders. The Examiners also found that there was a disproportionately higher number of services rendered OON for BH services and diagnoses than there were for M/S service categories.
57. The Examiners analyzed the claims data in Revenue Table 1, Tab 2 (Appendix E). This table shows a total of 63,714 revenue code-based facility claims, with 18,832 (29.6%) of these claims identified as M/S claims and 44,882 (70.4%) identified as BH claims. Of the total revenue code-based facility claims analyzed, 10,426 (16.4%) claims were identified as OON, 18.3% of which were M/S OON claims and 81.7 % of which were BH OON claims. After filtering the claims submitted by Blue Cross and analyzing the claim subset in Appendix E, the Examiners found that substantially more OON claims were for BH services than M/S services and that OON BH services were across all facility service levels, whereas M/S OON facility service categories were limited primarily to dialysis services.

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58. The Examiners further analyzed the claims identified in Para. 57 to determine what specific diagnostic categories were linked to M/S and BH OON claims. Revenue Table 2, Tab 2 further filters the claims found in Revenue Table 1, Tab 2 by only including the diagnostic categories with at least 25 OON claims. The Examiners found that Revenue Table 2 Tab 2 shows a pattern similar to the one noted in Para. 57, wherein a disproportionate number of OON claims were for BH. The total number of revenue code facility claims analyzed in Revenue Table 2, Tab 2 was 39,022, with 14,871 (38.1%) identified as M/S claims and 24,151 (61.9%) identified as BH claims. Of the total revenue code facility claims analyzed in this table, 10,238 (26.2%) were identified as OON claims, 16.2% of which were M/S OON and 83.8% of which were BH OON. A breakdown of the diagnoses associated with these OON revenue code-based facility claims reveals that dialysis services for end stage renal disease was the primary M/S OON diagnostic category (94.7%). The Examiners also found that services for substance use disorders at outpatient, partial hospitalization, inpatient and residential levels of care made up 85% of the BH OON claims, while major depression diagnosis at all levels of care made up 10% of the claims and a number of other mental health diagnoses made up the remaining 5%. See Revenue Table 2 in Appendix D for additional information to support these findings.

59. Based on findings in Paras. 57 and 58 and the additional data detailed in Revenue Tables 1 & 2, the Examiners found that the claims data suggested network inadequacies for dialysis services for end state renal disease and for all levels of care for substance use disorders. The Examiners also found that there was a

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disproportionately higher number of services rendered OON for BH services and diagnoses than for M/S services.

60. The Examiners further analyzed the professional code, facility code and revenue code claims tables (Appendix C, D and E) to determine the percentage of OON claims denied. The Examiners found that on average the number of sorted OON claims that were denied as a percentage of total claims was 6.3% and as a percentage of total OON claims it was 31%. The Examiners concluded that Blue Cross has an overall OON denial rate that indicates a significant majority of OON services are paid for and therefore clinically necessary covered benefits. However, OON services paid for by Blue Cross does not protect the beneficiary from balance billing by the OON provider. In addition, not having a sufficient number of INN providers to render clinically necessary services may cause Blue Cross beneficiaries to either not seek care or delay care due to the potential for additional financial risk if obtaining care from an OON provider.
61. Conclusions of Law and Statement of Concern. Based on the findings in Paras. 51-60, Blue Cross is in violation of 230-RICR-20-30-9.6 (E), as it did not maintain sufficient policies and procedures to identify network inadequacies. The Examiners also note their concern that there may be network inadequacies within Blue Cross's network, including in BH service categories.

Network Adequacy Recommendations

62. Blue Cross shall implement the following Recommendations in order to remediate the non-compliant patterns and practices and to address the areas of concern found by the Examiners and as described in Paras. 36-61. Within sixty days from

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the date the consent order is signed by both parties, Blue Cross should implement each of the following Network Adequacy Recommendations set forth in Paras. 63-66.

63. Blue Cross shall establish the following revised policies, procedures and processes, to include the following:

- A. A revised policy and mechanism to effectively determine whether its network is sufficient in volume and scope, such that its beneficiaries can obtain needed covered benefits in network. This policy shall include the effective use of claims, complaints, appeals, wait times, time and distance standards, member to provider ratios and other provider and consumer data to identify and then actively initiate efforts that minimize its network deficiencies. This policy shall also include a process to identify and document reasons for any network deficiencies and document Blue Cross's efforts to resolve any underlying issues leading to network inadequacies.
- B. A process to conduct quarterly reviews of its Network Adequacy activities according to 230-RICR-20-30-9.7 (B) within sixty days from the date the consent order is signed by both parties and to report the results of these quarterly reviews to OHIC by January 31, 2023.
- C. A revision of credentialing and recredentialing policies and the establishment of a process and an audit mechanism that ensures compliance with timelines and requirements set forth in R.I.G.L. § 27-18-83, R.I.G.L. §27-18-83, 230-RICR-20-30-9.8 (A) (5), 230-RICR-20-30-9.8

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(A) (3) (a) and 230-RICR-20-30-9.8 (D) (1-8). In the alternative, Blue Cross may submit revised credentialing and recredentialing policies to OHIC for approval pursuant to 230-RICR-20-30-9.8(E).

- D. A revision of contracting requirements, policies and processes to ensure that policies and procedures accurately reflect Blue Cross's practice in admitting providers to its network.
- E. A revision of the definition of BH Non-Life-Threatening Emergency, and if necessary related definitions, to ensure that this/these definitions clearly align within the definitions of urgent healthcare services as defined in R.I.G.L. § 27-18.9-2 (36) and 230-RICR-20-30-14.3 (39) and emergency services as defined in R.I.G.L. § 27-18.8-2 (10) and 230-RICR-20-30-9.3 (A) (12).
- F. An additional access standard for non-urgent, symptomatic care from a BH provider to be consistent with the access standards for non-urgent, symptomatic care from a primary care provider and a specialist provider.

- 64. Create a training manual that includes the revised policies and procedures noted in Para. 63 and provide training to the Blue Cross staff responsible for determining Network Adequacy, credentialing and contracting when any policies and procedures are revised and on a periodic basis no less than annually.
- 65. Develop a plan to investigate and address potential M/S and BH network inadequacies and report on such efforts to the Commissioner. The plan shall include:

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- A. Assessing available information, including, but not limited to claims data, regarding the reason for the use of OON providers at the rate of 5% or greater in certain service categories, including those categories identified in Paragraphs 53, 56 and 59;
- B. A process to identify and document on an annual basis rationale as to why Blue Cross does not contract with those OON providers who are providing medically necessary services to Blue Cross's beneficiaries;
- C. A process to explore the expansion of the use of telemedicine and/or other innovative delivery system options to assist in the de-escalation of beneficiaries BH issues to avoid the need for higher levels of care.

66. Revise its oversight programs to include a process to review activities, including contracting, credentialing, and any process that may negatively impact BH parity, when developing and maintaining its provider network. Further, for calendar year 2022 BCBSRI agrees to provide to the Commissioner, quarterly updates, 60 days after the close of each quarter, on its progress on the recommendations in the Report.

67. Within six months from the date the consent order is signed by both parties Blue Cross shall submit a revised and comprehensive Network Adequacy report to OHIC that is expanded in scope to include a systematic data driven process. This report shall include Blue Cross's plan to address minimizing any network inadequacies set forth in Para. 65.

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Appendix A

Information Data Request Log

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
Company Information and Provider Directory Requests		
1	October 11, 2019	<p>Please provide a written profile of the Company and its affiliates and subsidiaries, and include information regarding the Company history and management structure. This should include the date and location of formation, organizational and structural changes during the examination period through the current date, including Company names, management changes, acquisitions, lines of business, products, legal entity organization and management personnel and functional organization charts.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>
2	October 11, 2019	<p>Please provide a list of the Company's comprehensive major medical individual and group (small group and large group) insurance products, as defined under Rhode Island law, plan networks available to beneficiaries from January 1, 2019 through December 31, 2020 within the state of Rhode Island. Please provide a separate list for all new plan networks that will be introduced during 2020. Please Include the following information:</p> <ul style="list-style-type: none"> a. Network Name b. Network ID c. Network Size (based on number of beneficiaries served) d. Indicate the network tiers, if applicable e. Market Served (individual, large group, small group) f. Products Available (as applicable, PPO, EPO, POS, HMO, etc.) g. Servicing Area (as applicable, e.g., all of RI, by county, etc.) h. Will Network be available in 2020? (Y /N) <p>The Period that applies to this request is January 1, 2019 through December 31, 2020.</p>
2.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
2.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
3	October 11, 2019	<p>For each of the networks (and network tiers, if applicable) listed under request #2 (2019 networks only),</p> <ul style="list-style-type: none"> a. Provide an electronic copy (Excel or Word format) of the corresponding provider directories* as of the date of the current date in which this request is processed by the Company. If the network ID is not clearly listed in the provider directory file, please provide a key to identify which file is associated with each network. b. Also, please provide an Excel document listing the online web address for access to the 2019 provider directories for each of the identified networks. <p>*If the provider has more than one location in which services are provided, please include a separate line of data that is applicable to each location.</p> <p>The Period that applies to this request is September 2019, specifically, the date that the carrier processes this request.</p>
3.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
3.1.1	December 31, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
3.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
3.2 (Duplicate)	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4	October 28, 2019	<p>For each of the networks listed under request #2, provide a separate <i>Excel</i> document* <u>listing</u> of all providers including the following data fields:</p> <ul style="list-style-type: none"> a. Provider Name b. Provider NPI c. Regarding all type 2 NPIs (health organizations such as physician groups, hospitals, nursing homes, clinics, etc.), please include the type 1 NPIs and names (individual health providers such as physicians, licensed clinical social workers, etc.) for the individuals associated with the health organization. d. Provider Address including Zip Code (actual location where services are provided to members)** e. Provider County f. Provider Telephone Number g. Type of Provider as defined under Rhode Island Regulation 230-RICR-20-30-9.3 (23) h. Provider Specialty i. Provider Credentials/Licenses j. Handicap/Special Needs Accessibility (Yes or No) k. Age range of patients treated l. Date provider joined the network (contract date) m. Termination Date, if applicable n. Current Network Status (In-Network or Out-Of-Network) o. Network Tier, If applicable p. Is the professional provider as defined under Rhode Island Regulation 230-RICR-20-30-9.3 (22) accepting new patients? (Yes or No). If no, please provide the reasons why the provider is not accepting new patients q. Are there any limitations for access to care besides the non-acceptance of new patients with the professional provider? (Yes or No). If yes, please state the limitations and explain the reasons why such limitations are in place. r. Hospital admitting privileges (if applicable) or affiliation with in-network facilities s. Date of last filed claim for the provider <p>*Please label the Excel file with the corresponding network name.</p>

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<p>**If the provider has more than one location in which services are provided, please include a separate line of data that is applicable to each location.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>
4.1	February 26, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4.2	February 26, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4.3	February 26, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4.4	February 26, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4.5	February 26, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
5	October 11, 2019	<p>To the extent not included in request item #1 above, please provide electronic versions of current organizational chart(s) of each of the following business and/or operational units:</p> <ul style="list-style-type: none"> a. Provider Directory, including any staff available to assist members in finding care and those staff dedicated to provider directory updates b. Network Management, performance and adequacy monitoring c. Internal Audit d. Complaints and Grievances e. Professional Provider Credentialing/Re-Credentialing or Certifications f. Compliance regarding Rhode Island requirements <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
5.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
5.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
6	October 11, 2019	<p>Please provide the following information.</p> <ul style="list-style-type: none"> a. The policies and procedures used for updating the provider directory. b. Information provided to providers, including contact number and/or website to update provider contact information or status in the plan network. c. Internal timeline to complete provider directory update requests. d. Process for updating beneficiaries' access to updated provider directory information. e. The procedures for making provider directories available to beneficiaries, providers and the public. This information should include the formats available (print or electronic) and measures taken to accommodate individuals with limited English proficiency and/or disabilities. f. Process and method to inform and assist beneficiaries on how to choose and/or utilize a network plan, select or change a provider, access an updated provider directory in each network plan, and inform the members on the use of tiered networks within a network plan to include changes in beneficiaries' financial liability. Also, provide the dedicated line and telephone number that beneficiaries must call to request assistance with finding care and an available provider. <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above under items a, d, e and f. If such work flow charts do not exist, please create them.</p>
6.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
6.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
6.3	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
6.4	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
6.5	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
6.6	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
6.7	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
7	October 11, 2019	<p>Please provide the policies, procedures and controls for validating the information contained in the Provider Directory. Please include a summary explanation and details regarding the quality assurance program and quality reviews (QR's) performed prior to finalizing the Provider Directory.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p>
7.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
7.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

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7.3	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
7.4	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
7.4.1	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
8	October 11, 2019	<p>Please provide a list of all internal audits, internal compliance reviews and external audits conducted regarding provider directory accuracy and ensuring compliance with Rhode Island state regulations and statutes. For each, include a summary of the scope and indicate whether any issues were identified and/or corrective actions taken.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. Please provide the most recent internal audits, internal compliance reviews and external audits conducted. If such reviews were not performed during the Period, please provide your most recent audits.</p>
8.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
8.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
9	October 11, 2019	<p>For each of the networks listed under item #2, provide the corresponding member handbooks and evidence/certificates of coverage including the schedule of benefits.</p> <p>The Period that applies to this request is January 1, 2019 through December 31, 2020.</p>

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
10	October 28, 2019	<p>Provide the Company's complaints and grievances logs maintained during the Period. The log or report should contain the following information:</p> <ul style="list-style-type: none"> a. Policy number b. Network ID c. Source of complaint/grievance review request (beneficiary, provider, OHIC, claimant's attorney, etc.) d. Type of coverage (medical, mental health, etc.) e. Type of complaint/grievance (adequacy of network, provider directory error, etc.) f. Company identification number/code for the complaint/grievance g. Reason for complaint/grievance h. Date request received i. Date resolved j. Outcome <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>
10.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
10.2	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
10.3	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
		Network Adequacy Requests
11	October 11, 2019	<p>Please provide the policies, procedures, criteria, and selection standards used regarding the admission of providers to the Company's network. Also, include specific information regarding each type of provider and specialty such as medical, surgical, mental health and substance use providers.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the</p>

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		processes noted above. If such work flow charts do not exist, please create them.
		Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
11.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
11.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
11.3	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
11.3.1	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
11.3.2	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
11.4	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
11.5	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
11.6	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12	October 11, 2019	Provide the policies and procedures regarding the ongoing process in place to monitor and assure that the Company's provider network for each of its network plans (and network tiers, if applicable) are <i>sufficient in scope and in volume</i> to assure the network will: Address and monitor its population needs that all covered services for beneficiaries, including children, adults and low-income, medically

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		<p>underserved beneficiaries, children and adults with serious chronic and/or complex health conditions or physical and/or mental disabilities and persons with limited English proficiency, are accessible in a timely manner without unreasonable delay.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p> <p>Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>
12.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12.1.1	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12.1.2	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12.1.3	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12.3	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12.4	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
12.5	December 31, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12.6	December 31, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12.6.1	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
13	October 11, 2019	<p>Answer separately for each network (and network tier, if applicable):</p> <ol style="list-style-type: none"> Is the network open to any willing provider or does the network remain closed unless a specific need or gap is identified? Describe the methodology and provide supporting documentation. Does the Company's policy for maintaining an open or closed network admission process differ for certain specialties of providers based on gaps of coverage, shortages, areas of need, or quality of services, etc.? Describe the process and provide supporting documentation. Please indicate if the network will deviate in any way for 2020. If changes to the network will occur, please provide a detailed summary of such changes. Finally, please indicate if the network will terminate after December 31, 2019. In reference to all new networks that will be introduced during 2020, please provide a response to inquiries a. and b. above. <p>The Period that applies to this request is January 1, 2019 through August 31, 2019 and calendar year 2020.</p>
14	October 11, 2019	<p>Please provide the policies, procedures and protocols for evaluating the adequacy of the Company's network of providers.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p> <p>Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>

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14.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
14.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
15	October 11, 2019	<p>How frequently does the Company monitor the adequacy of providers for each network plan? Please provide documentation that supports the Company's compliance with 230-RICR-20-30-9.6(E) and 230-RICR-20-30-9.7(B).</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p> <p>Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>
15.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
15.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
15.3	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
15.4	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
15.5	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
16	October 11, 2019	<p>Please provide supporting documentation which models and identifies the Company's approach and methodology in making a determination regarding the adequacy of the provider network (including network tiers, if applicable). Documentation may include internal testing and applicable measures of the sufficiency of network coverage of all provider types such as behavioral health, medical providers including those that serve pediatric patients and complex diseases/conditions or co-morbidities and hospitals. Also, please provide any additional summary and details regarding how the Company measured In-Network participation of providers during the Period. Please include testing measurements, parameters, goals, and gaps identified based on but not limited to the following:</p> <ul style="list-style-type: none"> a. GeoAccess or similar tools and results applicable to the Period; b. Ratios of providers to covered persons; c. Waiting time for appointments; d. Other geographic accessibility testing, as measured by the reasonable proximity of participating providers to the business or personal residence of covered persons; e. Hours of operation; f. Availability of emergency care facilities and procedures; g. Volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. h. Out-of-network claims volume and the reasons for such claims. <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p> <p>Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>
16.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
16.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
16.3	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
17	October 28, 2019	<p>For each network separately (and network tier, if applicable), please provide an <i>Excel</i> document listing of all paid and zero paid (approved) claims (final adjudication), both in-network and out-of-network from September 1, 2017 through August 31, 2019 for policies/certificates issued in Rhode Island. The file(s) should include the following data fields:</p> <ul style="list-style-type: none"> a. Policy number b. Type of policy (individual, small group or large group and definition of each) c. Claim number d. Product/plan name e. Network ID f. Network tier, if applicable g. Date of service h. Date received i. Claim amount j. Allowable amount k. Paid amount l. Cost sharing amount applied (dollar amount beneficiary was responsible for) m. Provider Name n. National Provider Identifier (NPI) o. Network status (in or out-of-network) p. Actual provider address where the services were provided q. Type of service (emergency, inpatient, outpatient, partial hospitalization, residential treatment facility, office visit, etc.) r. Primary diagnosis code s. Secondary diagnosis code t. Tertiary diagnosis code u. All other available diagnosis codes in the system associated with the line item v. Procedure/Revenue code w. Remark Code x. Indicator for manual or auto adjudication y. Date approved z. Date paid

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<p>Please provide a data dictionary or legend that defines the Company's column headings and acronyms that may be used in the requested data. Also, provide a listing of all remark codes and their definitions.</p> <p>The Period that applies to this request is September 1, 2017 through August 31, 2019.</p>
17.1	February 26, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
17.2	February 26, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
18	October 28, 2019	<p>For each network separately, as applicable, please provide an <i>Excel</i> document listing of all denied claims (final adjudication), both in-network and out-of-network from September 1, 2017 through August 31, 2019 for policies/certificates issued in Rhode Island. The file(s) should include the following data fields:</p> <ul style="list-style-type: none"> a. Policy number b. Type of policy (individual, small group or large group and definition of each) c. Claim number d. Product/plan name e. Network ID f. Network tier, if applicable g. Date of service h. Date received i. Claim amount j. Allowable amount k. Provider Name l. NPI m. Actual provider address where services were provided n. Network status (in or out-of-network) o. Type of service (emergency, inpatient, outpatient, partial hospitalization, residential treatment facility, office visit, etc.) p. Primary diagnosis code q. Secondary diagnosis code r. Tertiary diagnosis code s. All other available diagnosis codes in the system associated with the line item t. Procedure/Revenue code u. Indicator for manual or auto adjudication

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<ul style="list-style-type: none"> v. Denial code w. Denial reason x. Date denied y. Date explanation of benefits mailed <p>Please provide a data dictionary or legend that defines the Company's column headings and acronyms that may be used in the requested data. Also, provide a listing of all denial codes and their definitions.</p> <p>The Period that applies to this request is September 1, 2017 through August 31, 2019.</p>
18.1	February 26, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
18.2	February 26, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
18.3	February 26, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
19	October 11, 2019	<p>For each network (and network tier, if applicable) separately, please define "excessive waiting time for an appointment". If this definition varies by type of provider and/or the type of service requested (periodic physical examination, diagnosis to treat severe symptoms, etc.), please include detailed information that applies to each provider and/or type of service.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>
20	October 28, 2019	<p>For each network (and network tier, if applicable) separately, please provide an <u>Excel listing</u> of all out-of-network (all health plans such as HMO, PPO, etc.) exception requests and decisions (where gaps in networks were identified, provider wait time for an appointment was excessive, etc.) made by beneficiaries or providers during the Period, which should include the following data fields:</p> <ul style="list-style-type: none"> a. Product/Plan name b. Reason for request

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		<p>c. Outcome (approved or denied) d. Percent of coverage (e.g., 100%, 50%, 0%, etc.) e. Service or procedural code requested f. Specialty of Provider requested g. NPI h. Provider address including zip code i. Provider county</p> <p>Please provide a data dictionary or legend that defines the Company's column headings and acronyms that may be used in the requested data.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>
20.1	December 23, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.2	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.2.1	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.3	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.4	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.5	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.6	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
21	October 11, 2019	Please provide the policies and procedures demonstrating that network plan beneficiaries have access to a provider in the event that the plan

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		<p>fails to maintain sufficient provider contracts, or a network provider is not available to provide covered services to beneficiaries in a timely manner.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p> <p>If the information requested is expected to change during 2020, please provide a detailed summary of such changes. Finally, please provide this information for all new networks that will be introduced during 2020.</p>
21.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
21.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
22	October 11, 2019	<p>Please provide the credentialing/re-credentialing policies and procedures clearly indicating the requirements for each type of covered professional provider within the plan network(s). Include copies of application forms, as applicable.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p> <p>Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>
22.1	December 23, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
23	October 28, 2019	For each network separately, as applicable, please provide an <u>Excel listing</u> of all professional provider credentialing or re-credentialing activities during the Period, which should include the following data fields:

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<ul style="list-style-type: none"> a. Provider Name b. Reason for request (credentialing or re-credentialing) c. NPI d. Provider address including zip code e. Provider county f. Receipt date of completed application or request g. Decision (approved or denied) h. Date of decision i. Date decision communicated to provider <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>
23.1	December 23, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
23.2	December 23, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
24	October 11, 2019	<p>Please provide an electronic copy of the written standard defining what elements constitute a complete credentialing and re-credentialing application. Please also provide the website address where this standard may be located.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>
24.1	December 23, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
25	December 31, 2019	230-RICR-20-30-9.5 provides, a health care entity must maintain regular and meaningful oversight of each of its delegates to ensure every such delegate is in compliance with the Act's network plan requirements. In addition, it also provides, for any portion of the health care entity's network plan activity that is delegated, the health care entity shall be responsible for oversight and be held accountable for all activity delegated and for any non-compliance of its delegate with the Act. The examiners were notified that the Company delegated some provider directory functions to NTT Data (NTT).

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		Please provide the following documents and/or additional information:
		1. Copy of the delegation agreement entered into between the Company and NTT.
		2. Please explain how the Company ensures through supervision and monitoring controls that NTT is performing the delegated functions in accordance with the agreement for provider directory.
		3. A listing of all provider directory related reports provided by NTT to the Company that allows BCBSRI to review and ensure the complete and accurate processing of updates (new providers, changes to provider information) to the provider directory. Please indicate the frequency of such reports, the individuals responsible for reviewing the information and the process for addressing identified issues (untimely transactions, high error rates, etc.) Please provide an example of each report. If the company did not require any reports from NTT, please explain.
		4. A listing of reviews performed by the Company to ensure that provider directory and delegated to NTT are being processed in accordance with Rhode Island requirements and the provisions as stated in the delegation agreement. If the Company did not perform any reviews, please explain.
		5. A listing of all provider directory quality review reports provided by NTT to the Company during the exam Period. Please explain how the Company used these reports to improve the quality of services provided by NTT. Please provide an example of each report. If the Company did not require any reports from NTT, please explain.
25.1	February 20, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
25.2	February 20, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
25.3	February 20, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
25.4	February 20, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
25.5	February 20, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
26	December 31, 2019	The following requests pertain to information discussed during the provider directory and network adequacy interviews conducted by RRC on December 18, 2019. Please provide the following:
		<p>1. Training materials used by NTT to train new employees and educate employees regarding Rhode Island requirements and changes to procedures. Please also include a narrative that explains this process.</p> <p>A timeline that states the number of days associated with the processing of updates to the provider directory. The timeline should begin with the date in which the update (new providers, changes requested by providers, etc.) is received by BCBSRI and continue through the date in which the update is submitted to NTT, the number of days required to make the update including processing the change in the provider directory system and the number of days in which the updated information is reflected and visible in the on-line provider directory that is accessed by beneficiaries.</p>

Appendix B

Claims Data Analysis

I. Introduction:

In response to Information Data Requests (IDRs) 17 and 18, the Carrier provided a separate Microsoft Excel document for each network (or network tier, if applicable), listing all zero paid approved claims as well as all adjudicated approved and denied claims. The claims represent both in-network and out-of-network claims from September 1, 2017 through August 31, 2019 (the "Data Period") regarding policies and certificates issued in Rhode Island.

II. Methodology to Analyze Claims Identified by Procedure Code:

A. Initial Procedure Code Filters.

Blue Cross and Blue Shield of Rhode Island ("Blue Cross") submitted 191 Excel spreadsheets for the Data Period, segmented on these excel spreadsheets by paid or denied, as well as professional and facility. These spreadsheets were consolidated into a unified data model in Microsoft Power BI, which collated 9,252,710 claims. 4,401,978 claims remained after the Examiners excluded the following coding classifications, which was done to isolate out-of-network claims by volume and to identify potential network inadequacies:

- CPT codes 00100 – 01999; 99100 – 99140: Anesthesia
- CPT codes 10021 – 69990: Surgery:
- CPT codes 70010– 79999: Radiology:
- CPT codes 80047 – 89398: Pathology and Laboratory
- A-codes: Transportation, Medical & Surgical Supplies, Miscellaneous & Experimental
- B-codes: Enteral and Parenteral Therapy
- D-codes: Dental Procedures
- E-codes: Durable Medical Equipment
- J-codes: Drugs Administered Other Than Oral Method, Chemotherapy Drugs
- K-codes: Temporary Codes for Durable Medical Equipment Regional Carriers
- L-codes: Orthotic/Prosthetic Procedures
- M-codes: Medical Services
- P-codes: Pathology and Laboratory
- R-codes: Diagnostic Radiology Services
- V-codes: Vision/Hearing Services

These 4,401,978 procedure-coded claims were subsequently separated by facility, representing 527,682 claims, and professional, representing the 3,874,296 claims. The Examiners then narrowed the claims data to only those facility and

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professional procedure codes where greater than 5% of the coded claims were out-of-network and where there were at least 25 claims for each code that was out of-network. After these two filters were applied, the remaining 106,008 professional procedure code claims and 33,344 facility procedure code claims were analyzed as noted below.

B. Professional Procedure Codes Analyzed

From the remaining 106,008 professional procedure coded claims, as shown in Professional Table 1, Tab 1, the Examiners removed procedure codes that had a similar service category to those service category codes already excluded via the process noted in Section II A above. Professional Table 1, Tab 2 identifies the remaining 49,505 professional procedure claims, which were then analyzed by the Examiners to assess network inadequacies, as presented in Para. 51 within the market conduct examination main report ("MCE"). The Examiners then reviewed the claims analyzed in Professional Table 1, Tab 2 to identify related diagnoses. Professional Table 2, Tab 1 shows these diagnoses and represents 40,905 claims. Professional Table 2, Tab 1 was then filtered to include only those codes with diagnoses that included at least 25 out-of-network (OON) claims, ultimately representing 31,938 claims (shown in Professional Table 2, Tab 2). The claims on Tab 2 were used to provide diagnostic detail on network inadequacies, as identified by the Examiners in Para. 52 of the MCE report.

C. Facility Procedure Code Claims Analyzed

The Examiners analyzed the 33,344 claims, as shown on Facility Table 1, Tab 1, and removed the procedure codes deemed similar to those service categories already excluded in Section II A above. Facility Table 1, Tab 3 identifies the remaining 26,988 facility procedure claims that were used by the Examiners to identify network inadequacies, as presented in Para 54 within the MCE report. The Examiners then reviewed the claims from Facility Table 1 to identify related diagnoses. Facility Table 2, Tab 1 shows these diagnoses, representing 20,515 claims. Facility Table 2, Tab 1 was then filtered to include only those codes with diagnoses that included at least 25 out-of-network claims, ultimately representing 18,214 claims (shown in Professional Table 2, Tab 3). The claims on Tab 3 were used to provide diagnostic detail on network inadequacies, as identified by the Examiners in Para 55 of the MCE report.

III. Methodology to Analyze Claims Identified by Revenue Code

A. Initial Revenue Code Filters.

Blue Cross submitted 191 Excel spreadsheets for the Data Period referenced above, segmented on these excel spreadsheets by paid or denied, as well as professional and facility. These were consolidated into a unified data model in Microsoft Power BI, which resulted in 9,252,710 claims. The Examiners used a revenue code to select only the claims identified as facility claims, which resulted in 2,805,315 claims. The Examiners then applied an additional filter to include, by revenue code, only those facility claims where greater than 5% of the coded claims were out-of-network and

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where there were at least 25 claims for each code that was out-of-network, which resulted in 88,235 claims.

B. Revenue Codes Analyzed.

The Examiners analyzed the 88,235 claims, as shown on Revenue Table 1, Tab 1, and removed the claims with revenue codes similar to the service categories already excluded in Section II A above. Professional Table 1, Tab 2 presents the resulting 63,714 revenue coded claims, which were then analyzed by the Examiners to identify network inadequacies, as presented in Paras. 57 in the MCE report. The Examiners further analyzed the claims in Revenue Table 1 to identify related diagnoses (Revenue Table 2, Tab 1) and applied a filter to require at least one (1) or more out-of-network claim as seen on Revenue Table 2, Tab 1. Revenue Table 2 Tab 1 and 2 represents the 39,022 claims used to provide diagnostic detail on network inadequacies as identified by the Examiners (Para 58 of the MCE report).

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Appendix C

Professional Procedure Data

Pursuant to R.I.G.L 27-13.1-5, the information contained in the Professional Procedure Data file has been deemed confidential and is not subject to the Access to Public Records Act, chapter 2 of title 38.

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Appendix D

Facility Procedure Data

Pursuant to R.I.G.L. 27-13.1-5, the information contained in the Facility Procedure Data file has been deemed confidential and is not subject to the Access to Public Records Act, chapter 2 of title 38.

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Appendix E

Revenue Code

Pursuant to R.I.G.L. 27-13.1-5, the information contained in the Revenue Code file has been deemed confidential and is not subject to the Access to Public Records Act, chapter 2 of title 38.

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Appendix F

OHIC Complaint Identifications

Pursuant to R.I.G.L. 27-13.1-5, the information contained in the OHIC Complaint Identifications document has been deemed confidential and is not subject to the Access to Public Records Act, chapter 2 of title 38.

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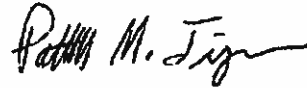
Wherefore, it is hereby ORDERED:

- A. The Commissioner hereby adopts the Examination Report and Recommendations.
- B. Blue Cross shall report to the Commissioner within six months from the date the consent order is signed by both parties regarding the implementation of all recommendations in this report.
- C. Blue Cross shall provide a compliance audit and other such information as reasonably requested by the Commissioner.
- D. In lieu of a penalty, Blue Cross shall make a financial investment into the Rhode Island doula workforce community in the total amount of \$100,000.00. The investment dollars shall be used to support Rhode Island doula workforce development and training. Further, as Blue Cross determines areas in need of investment, Blue Cross shall engage members of the Rhode Island doula workforce community as part of its process for identifying Rhode Island doula workforce community areas for its investments. It is the Commissioner's expectation that the \$100,000.00 financial investment in lieu of penalty shall be completed within three years of the date the consent order is signed by both parties. This doula investment payment shall be separate from, and in addition to Blue Cross' cost of implementing this Report's Recommendations and Orders.

In re Examination of Health Insurance Carrier Compliance with Network Adequacy and Provider Directory Laws and Regulations, Docket No. OHIC-2019-9

- E. Within 30 days of the issuance of this Order, Blue Cross shall file with the Commissioner affidavits executed by each Director of Blue Cross stating under oath that they have received a copy of the adopted Report and related Orders.
- F. The Commissioner shall retain jurisdiction over this matter to take such further actions, and issue any supplemental orders deemed necessary and appropriate to address the Report's findings, and to implement the Report's Recommendations, and Orders. Such further actions may include but not be limited to validation studies conducted by the Office to verify compliance with these Orders. Blue Cross shall pay the costs of any such further actions or supplemental orders.

Dated at Cranston, Rhode Island this 3rd day of February, 2022.



Patrick Tighe, Commissioner

THIS ORDER CONSTITUTES A FINAL ADMINISTRATIVE DECISION OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER. AS SUCH, THIS ORDER MAY BE APPEALED PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT, CHAPTER 35 OF TITLE 42 WITHIN THIRTY (30) DAYS OF THE DATE OF THIS ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION FOR REVIEW IN SAID COURT.

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Consent of Blue Cross and Blue Shield of Rhode Island

- I. Blue Cross understands and agrees that this Order constitutes valid obligations of Blue Cross, legally enforceable by the Commissioner.
- II. Blue Cross waives its right to judicial review with respect to the above-referenced matter; provided, however, Blue Cross shall have a right to a hearing on any charge or allegation brought by OHIC that Blue Cross failed to comply with, or violated any of its obligations under this Order, and Blue Cross shall have the right to appeal any adverse determination resulting from such charge or allegation.
- III. Blue Cross acknowledges and agrees that it consents to the legal obligations imposed by this Order, and that it does so knowingly, voluntarily, and unconditionally.
- IV. Notwithstanding the foregoing, this consent does not constitute an admission of any statement of fact or conclusions of law contained in the Examination Report or Order.

By:  Date: 2/10/22
Kristen McLean

Title: VP Legal Affairs + General Counsel

February 10, 2022

Patrick M. Tighe
Health Insurance Commissioner
Office of the Health Insurance Commissioner
1511 Pontiac Ave., Building 69-1
Cranston, RI 02920

Re: *Examination of Health Insurance Carrier Compliance with Network Adequacy
and Provider Directory Laws and Regulation, OHIC-2019-9*

Dear Commissioner Tighe:

Please accept this letter as Blue Cross & Blue Shield of Rhode Island's ("Blue Cross") written response to the above-referenced Examination Report (the "Report").

While Blue Cross acknowledges the legal validity and enforceability of the consent order in the Report, we believe that our practices during the examination period were generally consistent with both Rhode Island and federal laws, and we deny any wrongdoing or violation of law.

Notwithstanding, we agree with the Office of the Health Insurance Commissioner that adequate provider networks and accurate provider directories are important to ensure that our members can access the care they need. As a result, we are committed to enhancing our oversight of these areas to address the recommendations of the Examiners.

Sincerely,



Kristen Shea McLean
Vice President Legal Affairs, General Counsel