

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 Neighborhood Health Plan 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 Tigue

Health Insurance Commissioner

State of Rhode Island

Dear Commissioner Tigue:

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 Neighborhood Health Plan 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

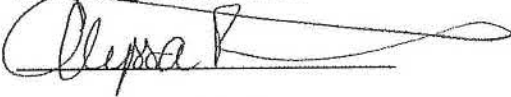


Victor Woods, Health Economic Specialist

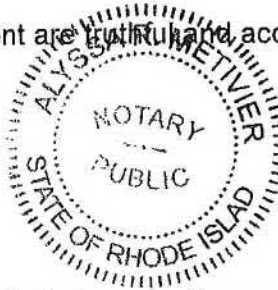
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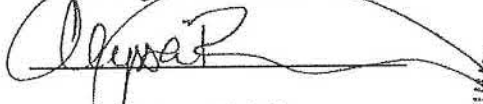
On this 3 day of February, 2022, before me, the undersigned notary public, personally appeared Emily Maranjian, personally known to the notary to be the person who signed the Examination Report in my presence, and who swore or affirmed to the notary that the contents of the document are truthful and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



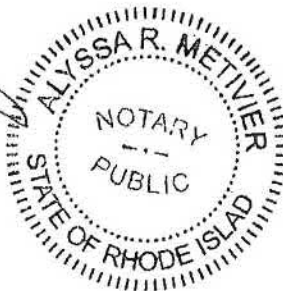
Notary Public



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 commercial insurance market: Blue Cross Blue Shield of Rhode Island ("Blue Cross"), Neighborhood Health Plan of Rhode Island ("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 Carriers' networks and the accuracy of the 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 Neighborhood and its delegate Optum Behavioral Health (BH Delegate). This Examination report does not purport to identify every instance or

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practice of non-compliance relative to Network Adequacy and accuracy of Provider Directories during the Exam Period¹. Any failure to identify a non-compliant practice shall 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 to 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 in order 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-20-20-9.5 (B) and 230-RICR-20-30-9.6 (E), to develop, implement and maintain a quality assurance program that provides oversight of all its 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's 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 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, 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 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 standards for BH providers when admitting them for participation in the carrier's network.

Rhode Island's parity law, R.I.G.L. § 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

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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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 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

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directs 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 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.

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

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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 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), 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

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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 provider 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 providers 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 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

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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 unknowing 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 45-calendar days after the date of receipt of a completed credentialing application. Further, 230-RICR-20-30-9.8 (D) sets forth that credentialing and re-credentialing applications shall 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

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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 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.

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B. The Examination targeted two areas of regulatory compliance (more detail is provided in the Information Data Request (IDR) documents which appear as items 1-27 in Appendix A), specifically:

- i. Compliance with state Provider Directory laws and regulations, with 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;
 - f. Beneficiary and provider communications regarding Provider Directories; and
 - g. Review of carrier complaints logs.
- ii. Compliance with state Network Adequacy laws and regulations, with particular focus on:
 - a. The carrier's policies, procedures, criteria, and selection standards regarding the admission of providers to the carrier's provider network;

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- 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;
- g. The carrier's ability to demonstrate that network plan beneficiaries have access to an OON provider in the event that 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 complaint logs.

C. Claims data submitted by Neighborhood in response to IDRs 17 and 18 were analyzed using Microsoft Power BI, which allowed Examiners to

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combine the submitted claim 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 two categories of claims and data tables:

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

Findings, Conclusions and Recommendations

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

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Complaint Findings and Conclusions

5. The Examiners reviewed Neighborhood's Complaint Processes and Complaint Log⁶, 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 Neighborhood's responses to any Provider Directory or Network Adequacy issues. This review led the Examiners to assess whether Neighborhood's Complaint Processes were compliant with Rhode Island law. The Examiners' findings and conclusions are as presented in Paras. 6 –14 herein.
6. In IDR 10.7 the Examiners requested that Neighborhood confirm that it provided all of the complaints received during the Exam Period in the previously provided Complaint Log. In response to IDR 10.7 Neighborhood stated that it "...has updated the Complaint report to meet this new request to include all complaints during the time period." The Examiners note that the initial IDR 10.0 request clearly stated, "Provide the Company's complaints and grievances logs maintained during the period." Neighborhood maintained that its final response to IDR 10.7 contained all its complaints for that period. The final Complaint Log included 82 complaints received during the Exam Period. Neighborhood only identified one as a BH complaint. Upon review, the Examiners found that 46 of the 82 complaints took longer than the Rhode Island required 30 days to resolve,

⁶ References to Neighborhood Complaint Log in this report refer to the documents submitted by Neighborhood in response to IDR 10.0 entitled "IDR10_Complaints and Grievances Log w Cover Sheet FINAL" along with documents submitted by Neighborhood in response to IDR 10.7 entitled "Complaints Follow Up IDR 10_Final".

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and 39 of the 82 complaints exceeded 60 days. For those complaints that exceeded the Rhode Island requirement, the time to resolve a complaint was as long as 244 days. Neighborhood demonstrated a pattern of delayed response, as evidenced by its resolution timeframes submitted for the Exam Period.

7. Conclusions of Law. Based upon the complaints that Neighborhood received during the Exam Period, as described in Para. 6, and the amount of time taken to resolve those complaints, Neighborhood is in violation of R.I.G.L. § 27-18.8-3 (b) (4) and 230-RICR-20-30-9.6(A)(2), as it did not process and resolve complaints within 30-calendar days.
8. In IDR 10.1 the Examiners requested that Neighborhood provide the definition it uses to identify all grievances, inquiries and complaints and explain its process to ensure all grievances, inquiries and complaints are recorded and responded to in a timely manner. In response to IDR 10.1, Neighborhood submitted a policy document titled "Exchange Member Complaints and Grievances". In this document Neighborhood defines an "Administrative Grievance/Complaint" as "A complaint related to billing issues or a member's dissatisfaction with Neighborhood staff, policies, processes, procedures, provider network, etc." and a "Clinical Grievance/Complaint" as "A complaint related to the quality of care rendered to a member by a provider or a Neighborhood vendor or partner." Upon review, the Examiners found that these definitions and policy statements indicate that Neighborhood has processes in place that are not in keeping with the statutory and regulatory definition of a complaint, as they do not require the

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processing of all communications of dissatisfaction. Neighborhood did not submit a BH Delegate complaint definition in response to this IDR.

9. In IDR 10.6, the Examiners requested that Neighborhood clarify when an inquiry becomes a complaint. Neighborhood responded, "Complaints are documented when the member informs the member service representative they would like to have their concern captured as a complaint, or language that demonstrates that they would like to have their dissatisfaction captured and investigated." This does not meet state requirements to process all complaints to include member communications that express dissatisfaction even in the absence of an explicit request by a member to capture or investigate a concern. Neighborhood did not submit a BH Delegate inquiry to complaint process in response to this IDR.

10. In response to IDR 10.6 that requested documentation to support Neighborhood's inquiry and complaint processes Neighborhood submitted a document titled "Member Complaint (Exchange)" which includes a procedure for its "inquiry process guideline." This procedure document describes the steps Neighborhood takes when processing telephonic complaints. The third bullet on page one of this document states, "Commercial Regulations do not require that we offer the complaint process during telephone calls, Commercial/Exchange members must specifically ask to file a complaint. If the member expresses dissatisfaction but does not ask to file a complaint / formal grievance, proceed to Step 4, wrap up the call, and do not fill out the template." According to Rhode Island requirements Neighborhood must process all communications of

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dissatisfaction as complaints. Neighborhood did not submit a BH Delegate communication process in response to this IDR.

11. In response to IDR 10.1, Neighborhood submitted a policy document titled "Exchange Member Complaints and Grievances". On page 3 of this policy Neighborhood states, "[the] Member or Authorized Representative must submit a Complaint or Grievance, either verbally, in writing or in person within one hundred and eighty (180) calendar days from the date of the event or incident that triggered the Complaint or Grievance." The Examiners concluded that limiting an individual to 180 calendar days from the date of the event or incident to file a complaint narrows the definition of a complaint as required under Rhode Island law. An "Authorized Representative" is defined as "An individual appointed by a Member in writing, or otherwise authorized by law to act on behalf of the Member." In this policy document providers are only mentioned when the complaint from a member or authorized representative is regarding a provider or when a provider is submitting a complaint to Neighborhood they received from a member. IDR 10 also asked that Neighborhood submit its complaint and grievance logs for the Exam Period. Upon review, there is no evidence of any provider complaints on the complaint log submitted. Further, the submitted policies and procedures related to complaints and grievances only reference members' rights in the complaint process and do not reference providers' rights, even though the latter is also required (See findings in Para. 8). Neighborhood did not submit a BH Delegate timeline noting a 180-day time limit or definition for Authorized Representative in response to this IDR.

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12. Conclusion of Law. Based on the review of Paras. 8 –11, Neighborhood, to include its BH Delegate did not define “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 definitions of “complaints” that were narrower in scope and did not include a “complaint” process to include a provider’s expressions of dissatisfaction. Further, Neighborhood, inclusive of its BH Delegate, is in violation of 230-RICR-20-30-9.3 (A) (4) which defines “Authorized representative” as an individual acting on behalf of the beneficiary and includes the ordering provider. As a result of this non-compliance by Neighborhood along with its BH Delegate’s failure to categorize and report all its complaints in accordance with R.I.G.L. § 27-18.8-3 (b) (4) and 230-RICR-20-30-9.6(A)(1)-(4). Failure to define, categorize, and report all complaints results in underreporting to OHIC and OHIC’s subsequent inability to determine Neighborhood’s compliance with the required processing of complaints. In addition, the Examiners were unable to accurately determine the level of member and provider Network Adequacy and Provider Directory concerns due to the underreporting of complaints by Neighborhood.
13. Neighborhood’s response to IDR 10.1 provided a policy titled “Exchange Member Complaints and Grievances,” page 5 of 9 states that Neighborhood processes complaints forwarded to it via its BH Delegate when the BH Delegate becomes aware of member dissatisfaction. The Examiners made a second request for all complaints from Neighborhood within IDR 10.7, a final complaint log was submitted yet only one of the 82 complaints were logged as a BH complaint for the Exam Period (See Para. 6). Upon review, there is no sufficient evidence that

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Neighborhood has a procedure in place to process, track, log, report and oversee BH complaints received by its BH Delegate. This low volume of BH complaints suggests that Neighborhood is either not overseeing its BH Delegate to assure that it's BH Delegate is capturing and reporting to Neighborhood all complaints and/or Neighborhood did not provide all the BH complaints logged by its BH Delegate in response to its final Complaint Log submitted in IDR 10.7.

14. **Conclusions of Law.** Based on the review of Para.13, the Examiners concluded that Neighborhood did not evidence that it tracks and logs all its BH Delegate's complaints in accordance with R.I.G.L. § 27-18.8-3 (b) (4) and 230-RICR-20-30-9.6 (A) (1-4). This failure to submit supporting documentation of the tracking and reporting of all BH complaints results in underreporting to OHIC and OHIC's ability to determine Neighborhood's oversight of their BH Delegate's compliance with the required processing of complaints. In addition, the Examiners were unable to accurately determine the level of member and provider BH Network Adequacy and BH Provider Directory concerns due to the underreporting of BH complaints by Neighborhood.

Complaints and Grievances Recommendations

15. Neighborhood shall implement, which implementation includes responsibility for ensuring similar implementation by its delegates, the following recommendations in order to remediate the non-compliant practices found by the Examiners and described in Paras. 6 – 14. On or before March 31,2022 Neighborhood shall implement each of the following Complaint Recommendations set forth in Paras.

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16 – 19 and further implement the Complaint Recommendation outlined in para 20 by the date specified.

16. Neighborhood shall establish Rhode Island specific policies and procedures⁷ 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), 230-RICR-20-30-9.3 (A) (4) and 230-RICR-20-30-9.6 (A) (1-4). This shall include a procedure to ensure that complaints are accurately categorized as complaints.
- c. Revise processes to ensure that complaints received from different areas in and outside of Neighborhood (e.g., delegates, Consumer and Provider Service Representatives, Customer and Provider Research staff and Complaint and Grievance staff, RIREACH, OHIC, and other state and federal agencies) are properly categorized and logged as complaints in a central complaint database and accurately reported to OHIC.

17. Neighborhood shall create a Rhode Island specific training plan and process for Consumer and Provider Service Representatives and any staff that receive and/or manage complaints. This training shall include the implementation of the Rhode Island specific policies and procedures noted in Para.16. Neighborhood

⁷ A Rhode Island specific policy or procedure document is a policy or procedure document that is wholly applicable to Rhode Island plans and shall not be satisfied by utilizing a Rhode Island addendum document to amend and or supplement a non- Rhode Island specific policy or procedure document.

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shall provide such training upon any revision of policies and procedures and on a periodic basis no less than annually.

18. Neighborhood shall establish a Rhode Island specific audit process to periodically monitor the activity of its and its delegates' Consumer and Provider Service Representatives and any staff involved in complaint receipt and processing to ensure compliance with its revised complaint policies and procedures.
19. Neighborhood shall establish Rhode Island specific processes and procedures regarding reporting and monitoring of complaints to ensure the accurate documentation and reporting of all its and its delegates' complaints to OHIC.
20. Neighborhood shall prepare and submit a report to OHIC which shall identify and summarize all complaints received by it and its delegate relating to Network Adequacy and Provider Directory issues during June 1, 2022 through December 31, 2022 that will be submitted on January 31, 2023. This report shall further convey how Neighborhood incorporated complaint information into its periodic monitoring and assessment of its Network Adequacy and Provider Directory accuracy

Provider Directory Findings and Conclusions

21. The Examiners reviewed Neighborhood's responses to the IDRs identified in each of the following paragraphs (See Appendix A for IDR details) in addition to follow-up questions as well as the interviews conducted with Neighborhood's staff on December 12th and 19th, 2019 (hereinafter "Interviews"), to evaluate the

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accuracy of Neighborhood's Provider Directory. The Examiners findings and conclusions are set forth in Paras. 22–32.

22. As part of IDR 3, the Examiners requested an electronic copy of Neighborhood's Provider Directories along with its online address for access to its 2019 provider directories. The Examiners evaluated the accessibility of Neighborhood's electronic provider directory via the website submitted by Neighborhood. The Examiners made several attempts to open the electronic provider directory through the link on Neighborhood's website but were not able to gain access on a consistent basis. Additionally, the Examiners reviewed the complaints filed by members to determine if any members had expressed similar problems or dissatisfaction with the electronic or paper provider directories. In a detailed review of the four member complaints that Neighborhood identified as relating to its provider directory, the Examiners found that these members had experienced issues and/or difficulty in either accessing a downloaded provider directory or accessing accurate information about the providers listed in the provider directory. Based on the Examiners' attempts and members' experiences, members and consumers do not have reasonable access to an accurate electronic provider directory on a consistent or reliable basis. These complaints are detailed as follows:

- a. Complaint ID# 1-, received on March 29, 2019, indicated that the provider directory website displayed incorrect provider location availability and inaccurately displayed a provider as accepting new patients. Upon review, this provider did not provide services from the location indicated in the

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provider directory and was not accepting new patients. The member had called the facility listed in the provider directory and spoke to a receptionist, who informed her that the listed provider did not work out of their Warwick location and only worked out of their Lincoln office, which contradicted the information provided in the electronic provider directory. She then asked if any of their providers at the Warwick location were accepting new patients and was informed that no providers there were accepting new patients, which again contradicted the information in the electronic provider directory. When Neighborhood investigated this complaint, the member's complaint was substantiated, and the errors were confirmed.

- b. Complaint ID# 2-, received on June 4, 2019, stated "Member called to file a complaint regarding the online provider directory. He states the 'Find a Doctor' search has incorrect information. Today he went on www.nhpri.org to find an in-network primary care provider, he selected accepting new patients' option. He called a few sites that came up on the results, and either the provider listed isn't accepting new patients or the provider that comes up in the results isn't at the practice." When Neighborhood investigated, the member's complaint was substantiated.
- c. Complaint ID# 3-, received on January 18, 2019, stated that the member had difficulty utilizing the Provider Directory. Though Neighborhood documented that it followed up with the member, at which time the member informed them that they no longer needed assistance, it took 152

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days for Neighborhood to resolve this complaint and ensure that the member had access to the needed information located in its electronic provider directory.

- d. Complaint ID# 4 -, received on January 29, 2019, was filed because a member could not easily access the online provider directory or locate a primary care physician who was taking new patients and needed to call into the customer service division to locate that information. When Neighborhood investigated, the member's complaint was substantiated.

23. Conclusions of Law. Based upon the findings in Para. 22, Neighborhood is in violation RIGL § 27-18.8 (c) (4), 230-RICR-20-30-9.7(D)(2) and 230-RICR-20-30-9.7(D)(3)(a), as its provider directories were not easily and consistently available to beneficiaries, providers, and the public in an electronic format. Members' inability to consistently access the electronic provider directory in a manner consistent with the regulatory provisions above limits their ability to search for and select providers and, therefore, could potentially inhibit access to needed care without delay.

24. The Examiners' reviewed Neighborhood's paper provider directory submitted in response to IDR 3. This paper provider directory revealed that certain provider fields, which should have included information that allowed members or consumers to search for a provider in a comprehensive manner, were populated with "N/A" instead of the relevant information. Fields populated with "N/A" included hospital admitting privileges. Hospital admitting privileges are required

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to be included on the paper provider directory according to Rhode Island rules, but this field was not populated for numerous providers.

25. Conclusions of Law. Based on the findings in Para. 24, Neighborhood is in violation of R.I.G.L. § 27-18.8 (c) (4) and 230-RICR-20-30-9.7 (D) (2) (c) (3), which requires Neighborhood to identify the status of a provider's hospital admitting privileges in its paper provider directories.
26. Neighborhood responded to IDR 6, which requested the policies and procedures used for updating its provider directory and the timelines for completing provider updates. In this response, Neighborhood provided its policies and procedures, as well as the policies and procedures of its BH Delegate. The BH Delegate's policy titled "MPD.01" states, "The Data Loading Analysts make the appropriate modifications within ten business days of receipt. When any of the following changes are submitted and do not involve a Tax ID Number (TIN) change, the directory will be updated within 10 business days." Upon review of these documents, there is no evidence that Neighborhood provided oversight or monitoring of its BH Delegate's policy and did not identify whether it was aware of its BH Delegate's non-compliance with of the Rhode Island requirements that obligates Carriers and their delegates to update minor demographic changes, including provider TINs, to provider directories within seven-business days.
27. In IDR 23.5 the Examiners requested that Neighborhood submit an excel spreadsheet that contained provider minor changes including but not limited to address changes and provider tax identification number (TIN) changes. In response Neighborhood submitted an excel document titled "IDR 23.5_Provider

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Minor Dem Changes_Neighborhood", which contained 100 minor changes that took place during the Exam Period. Of the 100 minor changes that occurred, 31 minor changes were completed beyond the seven-business day statutory and regulatory timeframe.

28. IDR 23.5 Examiners requested that Neighborhood submit an excel spreadsheet that contained its BH Delegate's provider minor changes including but not limited to address changes, provider tax identification number (TIN) changes. Neighborhood's BH Delegate submitted an excel document titled "IDR 23.5_Provider Minor Dem Changes_Optum", which contained 426 minor changes that took place during the Exam Period. Of the 426 minor changes that occurred, 141 minor changes were completed beyond the seven-business day statutory and regulatory timeframe.

29. Conclusions of Law. Based on the findings in Paras. 26 – 28 there is no policy language in place that requires Neighborhood's BH Delegate to update minor changes to demographic information in the provider directory within seven-business days, which is in violation of R.I.G.L. § 27-18.8-3, R.I.G.L. §27-18-83 (b) and 230-RICR-20-30-9.8 (A) (3) (b). Neighborhood's BH Delegate policy which clearly states that TIN changes are not considered minor changes; therefore, the BH Delegate does not require that TIN changes be updated within this seven-business day requirement. A TIN change is considered a minor change according to these Rhode Island statutes and regulations and thereby requires Neighborhood to process such changes in seven-business days. Neighborhood also did not provide documentation of its oversight and monitoring

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of the policies and procedures implemented by its BH Delegate regarding provider directory updates, which is in violation of 230-RICR-20-30-9.6 (E). Further, Neighborhood and its BH Delegate are in violation of 230-RICR-20-30-9.8 (A) (3) (b), which requires minor changes to the demographic information of a professional provider to be completed within seven-business days of receipt of the health care provider's minor change update request.

30. In IDR 25 the Examiners requested evidence of how Neighborhood monitors its BH Delegates processing of provider directory updates. Neighborhood provided a copy of its BH Delegate's policy in a document titled "OPT-145-Monthly Credentialing and Re-credentialing November_2019." Based on the information provided by Neighborhood, this BH Delegate policy had not been formally approved and does not appear to have been operational until after the Exam Period, as it was dated outside the Exam Period. There was no policy or report provided that evidenced Neighborhood's active oversight of the accuracy its BH Delegate's provider directory during the Exam Period. The information provided in response to IDR 25 indicated that Neighborhood had not received any Network Adequacy or Provider Directory quality review reports for the Exam Period that would have aided in regular and meaningful monitoring and oversight of its BH Delegate's activities.

31. IDR 8 requested a list of all internal audits, internal compliance reviews and external audits of Neighborhood's provider directory accuracy. In response, Neighborhood provided the following documents: "Provider Directory Content and Updates" Policy (Number: 000309); 2018 "Annual Provider Directory

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Accuracy Assessment” survey sample; 2018 “Physician Directory Accuracy Assessment” report; and Q2 2018 “Internal Audit Summary Report.”

Neighborhood also provided a copy of a document titled “CAP Report with a CAP Title: Provider Directory Q2 2018.” The dates on these assessments, surveys, reports and audit summaries indicate that they were all conducted in 2018.

Neighborhood did not provide any oversight review, audit or report documents that were dated and conducted within the Exam Period, as originally requested.

In addition to these documents, Neighborhood stated in response to IDR 8, “Neighborhood conducted an internal audit in Q2 2018 of its provider directory of its Medicare-Medicaid Plan (MMP) line of business. While we have not conducted a review specific to Neighborhood’s Commercial provider directory, the 2018 MMP audit represent CMS requirements.” Neighborhood did not indicate that it conducted any commercial product audits in 2019 to review the accuracy of its provider directory.

32. Conclusions of Law. Based on the findings in Paras. 30 – 31 Neighborhood’s written admissions, written responses, reports and the other internal documents revealed it did not conduct any quality assurance provider directory audits or provide any oversight of its BH Delegate’s provider directory for the Exam Period. Neighborhood is not in compliance with the requirements of R.I.G.L. § 27-18.8-3 (b) (1) and 230-RICR-20-30-9.6 (E), as it did not conduct any oversight assessments of the accuracy of its provider directory on a routine basis in order to ensure its ongoing compliance with 230-RICR-20-30-9.7 (D) (1)–(4).

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Provider Directory Recommendations

33. Neighborhood shall implement, and ensure that its delegates implement, the following recommendations in order to remediate the non-compliant practices found by the Examiners and as described in Paras. 22 – 32. On or before January 1, 2023, Neighborhood shall implement each of the Provider Directory Recommendations set forth in Paras. 34 – 36 as well as implement the Provider Directory Recommendation set forth in Para. 37 upon the date specified.
34. Neighborhood shall establish, and ensure that its delegates establish, Rhode Island specific policies, procedures and processes to assess and maintain an accurate provider directory to include the following:
- a. Consistent and compliant timelines for the accurate updating of electronic, paper and telephonic provider directories including, without limitation ensuring minor changes to demographic information are completed within seven-business days. 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. All required information is in its provider directories to include hospital admitting privileges in its paper directories;
 - d. An assessment of the availability and accessibility of its online provider directory to include an ongoing process that routinely checks on the

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consistency of its electronic provider directory availability and accessibility;
and

- e. A revised process for effectively auditing the accuracy of its provider directory and correcting any identified deficiencies. This process shall include at a minimum: periodic direct communications with INN providers to audit and ensure provider directory accuracy; auditing of a comprehensive number of provider types, to include BH delegate providers; mechanisms for ensuring provider directory accuracy across all provider types; and systematic use of data-driven information (e.g., claims, complaints, inquiry logs, credentialing, contracting) to inform and evaluate provider directory accuracy and compliance. This process shall also include mechanisms to correct identified deficiencies, improve upon provider directory error rates and document said corrections and improvements.

35. Neighborhood shall create a Rhode Island specific training plan and a process that includes the Rhode Island revised policies and procedures noted in Para. 34 and provide necessary ongoing training for staff whenever policies and procedures are revised and on a periodic basis no less than annually.

36. Neighborhood shall establish an ongoing audit mechanism for any and all delegates and contracted vendors responsible for provider directory updates to ensure compliance with R.I.G.L. § 27-18.8, 230-RICR-20-30-9.5 (B) (1), and the recommendations issued in this Examination report.

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37. On or before June 1, 2022 Neighborhood shall submit to the Commissioner for approval a plan for a master data management solution that consolidates disparate provider information received by Neighborhood and its delegates and enables Neighborhood to create a single, accurate source of up-to-date INN provider directory information.

Network Adequacy Findings and Conclusions

38. The Examiners reviewed Neighborhood's responses to the IDRs 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 Interviews conducted with Neighborhood staff. The Examiners findings and conclusions are as stated in Paras. 39 – 60.
39. The Examiners issued IDR 11 requesting the policies, procedures, criteria and selection standards used when admitting providers into Neighborhood's and its BH Delegate's network. Neighborhood subsequently provided its policies and the policies of its BH Delegate. Neighborhood submitted a Policy titled "Credentialing and Re-credentialing Policy & Procedure", which contained a provision on page 21 that states, "organizational providers are notified by Neighborhood's Credentialing Department of approval/re-approval within sixty (60) calendar days of the decision based on the completed and verified application." Neighborhood's BH Delegate document titled "Types of Clinicians and Eligibility Criteria, Policy Number C.01" was also provided but does not contain any information regarding the timeline for communicating a credentialing/re-credentialing decision to an

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applicant. The Examiners then issued IDR 11.1 requesting additional information regarding the Neighborhood BH Delegate's provider selection workflow and criteria. In response Neighborhood stated, "Information on Optums Credentialing procedures requiring applications to be processed within 45 days is included in the attached policy: IDR 22_OBH_RI Addendum_Credentialing_final, section 3." This attached addendum indicated compliance with the 45-calendar day requirement but the BH Delegate's policy effective date was not until August 2019 which was outside of a majority of the Exam Period. Neighborhood and its BH Delegate, therefore, did not maintain written policies to evidence compliance with the Rhode Island requirement to communicate its credentialing and re-credentialing decisions within 45-calendar-days of receipt of a completed application.

40. In IDR 11. 4 the Examiners requested information regarding the notification of credentialing and re-credentialing decisions to organizational providers versus individual providers for both Neighborhood and its BH Delegate. In response Neighborhood stated the following regarding its M/S provider network:
- "Organizational providers are notified of the decision within 45-calendar days of the complete and verified applications." In this response, Neighborhood indicated that applications needed to be "verified" before initiating the 45-calendar day timeline, which indicates that Neighborhood did not start counting the 45-calendar days at the point of a completed application but rather counting began only after the information in the completed application was verified. This delay in counting days is not in compliance with Rhode Island requirements and resulted

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in credentialing and re-credentialing decisions being made outside of the required Rhode Island timelines as evidenced in Para. 43.

41. In response to IDR 11 Neighborhood submitted its policies and workflows for credentialing and re-credentialing to substantiate compliance with Rhode Island's 45-calendar day requirement. A workflow document provided in response to IDR 11 and titled "Initial Credentialing Workflow" shows that an application is not considered complete until after primary and secondary source verification. IDR 11 also contains a document titled "Re-credentialing/Ongoing Monitoring Workflow," where it remains unclear when the 45-calendar day timeclock begins during the re-credentialing process. This same IDR response includes Neighborhood's policy titled "Credential and Re-credentialing policy and procedure." On page 18 of this policy, Neighborhood states, "...practitioners are notified of the CAC's decision by Neighborhood's Credentialing Department of their acceptance or denial within 45-calendar days based on the date of a completed and verified application."

42. In response to IDR 22, Neighborhood submitted its BH Delegate's workflow document, titled "Credentialing Flow-February 2018," which states in the heading portion of the document that "Credentialing Time frames are from Complete application received to Credentialing Decision Date. This timeframe is completed within 90 days." This February 2018 flow chart indicates that Neighborhood's BH Delegate had a timeline beyond the state required 45-calendar-day requirement.

43. In IDR 23, for each of Neighborhood's networks, the Examiners requested all professional provider credentialing and re-credentialing activities that took place

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during the Exam Period. However, rather than submitting all credentialing and re-credentialing activities, Neighborhood only submitted data for approved or denied credentialing and re-credentialing cases (i.e., Neighborhood did not produce data related to submitted credentialing or re-credentialing applications which were not approved or denied). As a result, Examiners issued IDR 23.4 requesting a complete set of all credentialing and re-credentialing activities for the Exam Period. In response to IDR 23.4, Neighborhood submitted revised credentialing and re-credentialing activity logs but did not provide all requested data fields. A review of tab 1 of this log titled "MCE-IDR 23 2", revealed a total of 431 credentialing and 1383 re-credentialing cases. Missing from Neighborhood's revised re-credentialing portion of its log were several data points important to the Examiners review. For 206 re-credentialing cases, Neighborhood did not comply with the Rhode Island requirement to complete the application within 45-calendar days of receipt. For 13 credentialing applications, Neighborhood did not comply with the Rhode Island requirement to complete the application within 45-calendar days of receipt. Additionally, the Examiners find that Neighborhood was not in compliance, with respect to each credentialing application, to evidence that: (a) each applicant, was provided with a update regarding the status of their credentialing application at least once every 15 days informing them of any missing information up until such time as their application being complete; (b) Neighborhood provided notice to the applicant within five business days of the application being complete; and (c) Neighborhood notified the applicant of its

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credentialing decision within 45-calendar days of receipt of a completed application.

44. IDR 23.4 Examiners requested a complete set of all credentialing and re-credentialing activities for the Exam Period. Tab 2 of this document is titled "application tracking". Based upon a review of this tab, Neighborhood does not track re-credentialing activities, the "application tracking" tab only included credentialing activities. Due to Neighborhood's inability to provide the Examiners with its re-credentialing activity, Neighborhood did not evidence that it provided applicants with an update on the status of its re-credentialing application at least once every 15 days informing them of any missing information.
45. The Examiners requested in IDR 23 that Neighborhood provide for each of its networks all professional provider credentialing and re-credentialing activities. Examiners issued IDR 23.1 to Neighborhood to confirm whether the Examiners were correct in finding Neighborhood did not submit requested credentialing and re-credentialing activity data performed on Neighborhood's behalf by Neighborhood's BH Delegate in response to IDR 23. In response, Neighborhood stated, "The data requested is not a required reporting piece from the Delegate and is not loaded into the Optum database." As a result, the Examiners then requested that Neighborhood produce a complete set of all credentialing and re-credentialing activities for the Exam Period. In response, Neighborhood submitted credentialing and re-credentialing information for its BH Delegate within document "Optum IDR 23_RI OHIC_Clinician Universe_Updated_081621v2.xls." For 12 credentialing cases, Neighborhood's

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BH Delegate did not comply with the Rhode Island requirement to complete the application within 45-calendar days of receipt. For 27 re-credentialing applications, Neighborhood's BH Delegate did not comply with the Rhode Island requirement to complete the application within 45-calendar days of receipt. Additionally, the Examiners find that Neighborhood's BH Delegate was not in compliance, with respect to each credentialing application, to evidence that: (a) each applicant was provided with a update regarding the status of their credentialing application at least once every 15 days informing them of any missing information up until such time as their application being complete; (b) the BH Delegate provided notice to the applicant within five business days of the application being complete; and (c) the BH Delegate notified the applicant of its credentialing decision within 45-calendar days of receipt of a completed application.

46. Conclusions of Law. Based on the findings in Paras. 39 – 45, Neighborhood and its BH Delegate are in violation Rhode Island requirements R.I.G.L. § 27-18.8-3 (d) (2) (i), R.I.G.L. § 27-18-83 (a) and 230-RICR-20-30-9.8 (A) (3) (a), which requires credentialing and re-credentialing decisions be communicated to applicants no later than 45-calendar days after the receipt of a completed application. In addition to failing to provide all the requested credentialing and re-credentialing information and define a "completed" application in a manner that is compliant with 230-RICR-20-30-9.8 (D) (1-8), the Examiners conclude that, based on the information provided in these IDR responses, Neighborhood and its BH Delegate did not meet the 45-calendar day notification requirement for

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communicating all of its credentialing and/or re-credentialing decisions. Further, Neighborhood along with its BH Delegate are in violation of 230-RICR-20-30-9.8 (A) (5), and 230-RICR-20-30-9.8 (A) (6) as both entities did not provide evidence to Examiners to substantiate updating and tracking all applicants on the status of their credentialing and re-credentialing application at least once every 15 days informing them of any missing information as well as failed to inform the provider that the credentialing and re-credentialing application is complete within five business days of correctly determining the application to be complete. Finally, in violation of R.I.G.L. § 27-18.8-3 (b) and 230-RICR--20-30-9.6 (E), Neighborhood did not adequately oversee its BH Delegate to ensure compliance with statutory and regulatory guidelines for its credentialing and re-credentialing process.

47. In response to IDR 16, Neighborhood submitted time and distance access standards for its M/S and BH INN providers. Distance Standards for Primary Care, OB-GYN and Specialty Providers are 2 within 10 miles, 2 within 10 miles, and 1 within 15 miles respectively. However, BH providers, including acute inpatient care providers, have distance standards that range from 1 within 30 miles to 1 within 40 miles. Upon the Examiner's review, Neighborhood's BH provider distance standards are different than Neighborhood's M/S distance standards.
48. Statement of Concern. Based on the findings in Para. 47 the Examiners note their concern that Neighborhood BH Delegate's distance standards (measured in providers to miles) for access to BH services were different from the standards set for Neighborhood's M/S services and may be less favorable to the member.

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49. Neighborhood's response to IDR 16 also included its BH Delegate's policy titled "Access Standards and Hours of Operation". This policy states that its standard for access to BH urgent care is 48 hours. Further, an excerpt from Neighborhood's "Provider Manual" states the M/S standard for urgent care access is 24 hours. Not only is there a difference between BH and M/S having a BH 48-hour timeline, this BH standard is not compliant with the state regulatory requirement that all urgent care treatment be made available in no more than 24 hours.
50. In response to IDR 16 Neighborhood submitted its BH Delegate's "Follow-Up Routine Care" access standards in a policy titled "Access Standards and Hours of Operation". This policy describes having two distinct wait-time standards: one for access to BH Prescribers (less than 60 days) and one for BH Non-Prescribers (less than 30 days). Such a distinction between Prescribers and Non-Prescribers is not found in Neighborhood's M/S network wait-time standards for routine care or follow-up routine care.
51. In IDR 16 Neighborhood's BH Delegate makes the distinction between BH Emergency and BH non-life-threatening Emergency in a document titled "Access Standards and Hours of Operation" This policy presents that Neighborhood requires BH Emergency services to be immediately available. However, Neighborhood has a different timeline standard for access to BH non-life-threatening Emergency services, which is 6 hours. There is no such distinction for M/S Emergency services for which Neighborhood requires immediate access. State of Rhode Island rules require immediate access for all emergency services.

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52. Conclusions of Law and Statement of Concern. Based on the findings in Paras.

49 – 51, Examiners note their concern that Neighborhood's BH Delegate provider access to services standards are different to the beneficiary than its access to services standards for Neighborhood's M/S services. Such differences may lead to more access to care issues for members seeking BH services. Further, Examiners also note that Neighborhood's BH Delegate is in violation of R.I.G.L. §27-18.8-2 (10), 230-RICR-20-30-9.3 (A) (12) and 230-RICR-20-30-9.7 (A) (2), which define an emergency as a M/S or BH condition in which the absence of immediate attention places a person's health in jeopardy or could result in serious dysfunction and require that all emergency services be accessible 24 hours a day, 7 days a week. The BH Delegate's 6-hour access standard for BH non-life-threatening emergencies violates these requirements. Neighborhood's BH Delegate's BH urgent care access standard of 48 hours is in violation of the Rhode Island urgent access requirements which requires care within a 24-hour period pursuant to 230-RICR-20-30-14.3 (A) (39). Finally, Neighborhood is in violation of R.I.G.L. § 27-18.8-3 (b) and 230-RICR--20-30-9.6 (E), as Neighborhood failed to document adequate oversight of its BH Delegate to ensure its compliance with all state and federal requirements.

53. The Examiners analyzed the claims data in Procedure Code Table 1, Tab 3 (Appendix C). Table 1 Tab 3 of this table includes 98,191 professional and facility procedure code claims with 16,736 (17.0%) of these claims identified as M/S, 55,150 (56.2%) identified as BH and 26,305 (26.8%) identified as SH. Of the total procedure code claims analyzed, 10,706 (10.9%) were identified as OON with

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1,461 (13.6%) of the total OON claims identified as M/S OON claims, 3,821 (35.7%) identified as BH OON claims, and 5,424 (50.7%) identified as SH OON claims. The following categories of services had more than 10% OON: unspecified mental health services, drug testing to identify methadone, case management alcohol/drug, community support services, psychotherapy and self-help/peer services, nursing facility care, observation care, acupuncture, critical care, emergency care, case management and after hour facility services (See Appendix C, Tab 3 Procedure Code Table 1 for details). The Examiners note that Neighborhood approved an average of 57.6% of all OON claims.

54. The Examiners further analyzed the claims identified in Para. 53 to determine what specific diagnostic categories were linked to these M/S, BH and SH OON claims. Procedure Code Table 2, Tab 3 provides more diagnostic detail on the OON claims found in Procedure Code Table 1, Tab 3 after filtering the claims to only include diagnostic categories with at least 6 OON claims (more detail provided in Appendix B). The Examiners separated the SH claims on Procedure Code Table 1, Tab 3 into M/S and BH based on the listed diagnostic categories. Upon review of the 64,203 filtered procedure code claims (INN and OON) found in Procedure Code Table 2 Tab 3, the Examiners identified 12,245 (18.9%) as M/S and 52,058 (81.1%) as BH. The Examiners then reviewed these total filtered procedure code claims (INN and OON) to reveal that 47,266 or 73.6% of the total claims on Procedural Code Table 2, Tab 3 were for "Alcohol and/or RX Services; Methadone Admin & Or Services" for members with a diagnosis of "Opioid dependence uncomplicated" and 9,980 or 15.5% of the total claims on Tab 3 were

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for "Emergency Department" services with over a 130 different diagnoses with the majority of diagnoses related to musculoskeletal pain or injury, GI issues or pain, cardiovascular related symptoms, upper respiratory symptoms/disease/infections, and kidney related symptoms. Of the total professional procedure codes analyzed in Procedure Code Table 2, Tab 3, 6,956 (10.8%) were identified as OON claims, 3,061 (4.8%) of which were M/S OON claims and 3,895 (6.1%) of which were BH OON. Of the total OON claims, 2,564 or 36.6% were for "Alcohol and/or RX Services; Methadone Admin & Or Services" for members with a diagnosis of "Opioid dependence uncomplicated" and 2,439 or 35.06% were for "Emergency Department" services with over 130 different diagnoses for diagnoses related to musculoskeletal pain or injury, GI issues or pain, cardiovascular related symptoms, upper respiratory symptoms/disease/infections, and kidney related symptoms. Of the total M/S and BH OON claims identified in Procedure Code Table 2, Tab 3 47.3% were approved. See Procedure Code Table 2 in Appendix C for additional information to support these findings.

55. Based on the data analysis in Paras. 53 and 54 and the additional data analysis detailed in Procedure Code Tables 1 & 2 (Appendix C), the Examiners found that the claims data indicated the need to further evaluate the potential for network inadequacies for services related to the treatment of opioid dependency and emergency services for a number of M/S issues. Though OON services were approved at a high rate it is important to determine if these high OON rates result in an inadequate network as an inadequate network of providers may result in members not seeking or delaying a needed service due to the potential for

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additional costs for OON services. In some circumstances, members may also unknowingly receive services from an OON provider, resulting in the unexpected financial burden of paying for these services.

56. The Examiners analyzed, filtered and sorted the claims data in Revenue Code Table 1, Tab 3 (Appendix D). Tab 3 of this table shows a total of 64,759 revenue code-based claims, with 25,823 (39.9%) of these claims identified as M/S claims, 161 (.25%) identified as BH claims and 38,775 (59.9%) identified as SH claims. Of the total revenue code claims analyzed, 4,611 (7.1%) were identified as OON, 723 (15.7%) of which were M/S OON claims, 25 (.5%) of which were BH OON claims and 3,863 (83.3%) of which were SH OON claims. An average of 80.7% of Revenue Code OON claims are approved.

57. The Examiners analyzed the claims identified in Para. 56 to determine what specific diagnostic categories were linked to M/S and BH OON claims. Revenue Code Table 2, Tab 2 further filters the claims found in Revenue Code Table 1, Tab 3 by only including the diagnostic categories with at least 6 OON claims. The Examiners also separated the SH claims on Revenue Code Table 1, Tab 3 into M/S and BH based on the listed diagnostic categories. The total number of revenue code facility claims analyzed in Revenue Table 2, Tab 2 was 9,485, with 8,991 (94.8%) identified as M/S claims and 494 (5.2%) identified as BH claims. Of the total revenue code facility claims analyzed in this table, 2,316 (24.4%) were identified as OON claims, 2,172 (93.8%) of which were M/S OON and 144 (6.2%) of which were BH OON. Revenue code claims with greater than 100 claims (INN and OON) by diagnoses revealed that emergency room services made up 85.7%

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of those claims with related to diagnoses of muscle strain/pain, chest pain, GI issues, headache, URI, HTN, ETOH abuse, anxiety, MDD, and viral issues; and physical therapy services made up 5.4 % of those claims with noted diagnoses of muscle weakness and low back pain. See Revenue Code Table 2 in Appendix D for additional information to support these findings and conclusions. Of all Neighborhood's OON claims on Revenue Table 2, 81.6% are approved.

58. Based on findings in Paras. 56 and 57 and the additional data detailed in Revenue Code Tables 1 & 2; the Examiners found that the claims data indicated a correlation between the OON emergency room procedure code claims and the OON emergency room revenue code claims, which the Examiners find require further analysis by Neighborhood in order to determine the potential for network inadequacies related to emergency room services for a number of diagnostic categories. Though a significant portion of OON services were approved, members may ultimately not seek services or delay obtaining services due to the potential additional cost of OON services. In some circumstances, members may have unknowingly received services from an OON provider, thereby having the financial burden of paying for these services.

59. The Examiners further analyzed the procedure code and revenue code claims tables (Appendix C and D) to determine the average percentage of OON claims denied. The Examiners found that on average the number of OON procedure code claims on Procedure Code Tables 1 and 2 that were denied as a percentage of the total procedure code claims was 5.15% and as a percentage of total OON procedure code claims it was 47.6%. The Examiners also found that

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on average the number of OON revenue code claims on Revenue Code Tables 1 and 2 that were denied as a percentage of the total revenue code claims was 2.95% and as a percentage of total OON revenue code claims it was 18.9% (See Revenue Table 2 Tab 3 for this data summary). The Examiners concluded that Neighborhood has an overall OON denial rate that indicates a majority of OON services are approved and therefore clinically necessary covered benefits. However, OON services approved by Neighborhood does not fully protect the beneficiary from balance billing by the OON provider beyond what the beneficiary is liable for INN. In addition, not being able to determine whether a sufficient number of INN providers are available to render clinically necessary services may cause Neighborhood beneficiaries to either not seek care or delay care due to the potential for additional financial risk if obtaining care from an OON provider.

60. Conclusions of Law and Statement of Concern. Based on the findings in Paras 39 - 59. Neighborhood 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 a concern that their analysis of Neighborhood's data indicates a need for Neighborhood to further evaluate whether there may be network inadequacies within Neighborhood's network.

Network Adequacy Recommendations

61. Neighborhood and its delegate shall implement the following Recommendations in order to remediate the non-compliant patterns and practices found by the Examiners and described in Paras. 34 – 60. On or before the dates referenced

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below, Neighborhood shall implement each of the Network Adequacy recommendations set forth in Paras. 62 – 67.

62. Neighborhood shall establish the following revised Rhode Island specific policies, procedures and processes that are to include the following:

- a. A revised policy and mechanism to effectively determine whether its network is sufficient in volume and scope on or before June 1, 2022, such that its beneficiaries can obtain needed covered benefits. This policy shall include the 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 the reasons for identified network deficiencies and document Neighborhood's efforts to resolve the underlying issues that lead to network inadequacies;
- b. A process to conduct quarterly reviews of its Network Adequacy activities, including those of its delegate, in accordance with 230-RICR-20-30-9.7 (B), and to report the results of this quarterly review to the OHIC on or before January 31, 2023;
- c. A revision of its credentialing and re-credentialing policy on or before March 1, 2022 and the establishment of a process and an audit mechanism that ensures compliance with the 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

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(A) (5), 230-RICR-20-30-9.8 (A) (3) (a) and 230-RICR-20-30-9.8 (D) (1-8)

on or before January 1, 2023;

- d. A process to conduct reviews of its BH delegate(s) credentialing and re-credentialing activities on a quarterly basis to ensure compliance with 230-RICR-20-30-9.8 (A) - (D) on or before January 1, 2023; and
- e. A revision of the policies and procedures for access standards on or before June 1, 2022 to ensure that the same standards are applied to BH and M/S providers, including:
 - i. Time and distance standards;
 - ii. Provider to patient ratio standards;
 - iii. Access to prescribing and non-prescribing provider standards; and
 - iv. Access to emergency services for BH and M/S twenty-four (24) hours a day, seven (7) days a week.

63. Create a Rhode Island specific training plan on or before July 1, 2022 that includes the revised Rhode Island specific policies and procedures noted in Para. 62 and provide training to the Neighborhood and its delegate staff responsible for determining Network Adequacy and credentialing/re-credentialing when any policies or procedures are revised and on a periodic basis no less than annually.

64. Develop a plan to investigate and address potential M/S and BH network inadequacies and report on such efforts to the Commissioner on or before January 1, 2023. The plan shall include:

- 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

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greater in certain service categories, including those categories identified in Paras. 55 and 58;

- b. A process to identify and document on an annual basis rationale as to why Neighborhood does not contract with those OON providers who are providing medically necessary services to Neighborhood'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.

65. On or before June 1, 2022, Neighborhood shall 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.

66. Neighborhood agrees to provide four quarterly updates to the Commissioner over the course of the year following execution of this agreement documenting its progress on the recommendations in the Report. Further, each quarterly update shall be sent 60 days after the close of each quarter.

67. On or before January 31, 2023, Neighborhood 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 Neighborhood's plan to address minimizing network inadequacies set forth in Para. 64.

Obligation to Facilitate the Examination: Findings and Conclusion

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68. Throughout the course of the Examination, the Examiners repeatedly experienced challenges in obtaining complete, accurate and timely information from Neighborhood in response to the IDRs. The Examiners reviewed Neighborhood's responses to the IDRs summarized 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 conducted interviews with Neighborhood's staff to assess whether Neighborhood facilitated the Examination and aided in the Examination so far as it was in their power to do so and/or whether Neighborhood, by their responses, effectively failed to comply with reasonable written requests of the Examiners.
69. Neighborhood did not provide requested and required information, policies, procedures, and data elements necessary for Examiners to conduct a full examination of its and its Delegate's Provider Directory and Network Adequacy. Neighborhood and its Delegate submission responses to initial requests for information, policies and procedures and data were often inadequate, incomplete, or contained errors resulting in the Examiners need to repeat such requests. (Examples in IDRs 4, 4.1, 5, 6, 6.1, 8, 10, 10.7, 11, 11.1, 11.2, 21, 21.5, 27, 22, 22.2, 23, 23.2).
70. Neighborhood's responses to the requests for information, policies, procedures, and data were often delayed with Neighborhood requesting multiple extensions and requesting these extensions on or shortly before the response due dates. This resulted in delays in the completion of the MCE. (Examples in IDRs 4, 4.1, 5, 6, 6.1, 8, 10, 10.7, 11, 11.1, 11.2, 21, 21.5, 27, 22, 22.2, 23, 23.2).

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71. In many instances, when Neighborhood was notified by Examiners that it had neglected to provide a complete response to the Examiners' request, Neighborhood responded with "Neighborhood overlooked including this policy in the initial response" or information was excluded in error. The Examiners find that Neighborhood's reliance on this response, and the other Obligations to Facilitate the Examination findings, evidence both Neighborhood's lack of effort to fully assess what the Examiners initially requested in order to provide a complete and accurate response and Neighborhood's lack of an effective review of its response for accuracy and completeness prior to submitting the requested information to the Examiners. (Example IDRs 4.1, 11.1, 11.4, 22.2 and 22.3).
72. Neighborhood frequently provided data, audit, and informational responses that did not include explanatory information sufficient for the Examiners to assess the responses sent. Neighborhood also neglected to provide Examiners with a reason why specific elements of certain requests were not submitted. This necessitated additional questions from Examiners and resulted in further MCE delays. (Example IDRs 8.0, 21, 21.5, 22.2, 23, 26.4, 17 & 18).
73. Examiners found that information given during the interviews was inconsistent with the written policies and procedures submitted by Neighborhood. The Examiners find that this indicated Neighborhood's lack of preparedness, coordination, and review of the information communicated to OHIC to facilitate this MCE. (Example Interviews and IDR 26.4).
74. The Examiners found that Neighborhood failed to make a reasonable effort to obtain timely, accurate and complete claims data for one of its BH Delegates in

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response to IDRs 17 and 18 thereby hindering the MCE. The Examiners concluded that had Neighborhood made a sufficient effort initially to obtain the requested information the Examiners would not have been compelled to waste a significant amount of time and effort attempting to obtain the data necessary to this Examination. In addition, important claims information was not initially fully disclosed to the Examiners in response to a clear request. While Neighborhood provided data on whether these claims were eventually paid, Neighborhood did not verify the actual network status and validity of each original claim, leaving the Examiners with incomplete data. After four attempts to retrieve the correct data for the Examination, Neighborhood was unable to produce accurate information as requested. Furthermore, the incomplete claims datasets submitted as part of the Examination could not be effectively evaluated by the Examiners thereby negatively impacting the Examiners ability to determine network adequacy using these claims.

75. Conclusions of Law. Based on the findings in Paras. 68 – 74, Neighborhood is in violation of § 27-13.1-4(b) because, due to insufficient information and delayed responses, it did not provide "timely, convenient and free access" to the materials, policies, and information necessary to conduct the Examination and did not do everything in its "power" to "facilitate" and "aide" the Examination. As stated in § 27-13.1-4(b), "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." In this case, Neighborhood had the ability and power to oversee and obtain necessary information regarding its BH

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delegate's activities during the Examination but did not do so. Neighborhood and its BH delegate's responses were incomplete, Neighborhood frequently requested additional time to complete responses, and/or to correct earlier incomplete responses to the Examiners' requests. As a result, the work of the Examiners was impeded. This Examination was compromised, and the Examiners find that the inaccuracies in the submission of data and information impeded their ability to comprehensively assess Neighborhood and its BH delegates' Network Adequacy and the accuracy of Neighborhood's Network Directories. The Examiners also, therefore, conclude that though they were able to determine violations of federal and state statutes and regulations as presented in this MCE report, the determination of the full scope and severity of the inadequacy of Neighborhood's and Neighborhood's BH delegates' networks, complaint and credentialing process and Provider Directories was negatively impacted.

Obligation to Facilitate the Examination: Recommendations

76. Within 60 days of issuance of this report Neighborhood shall submit a plan acceptable to the Commissioner to evidence the steps Neighborhood will take to address the violations set forth in the report's Obligations to Facilitate Paras. 68 – 75. This plan shall ensure prompt and effective compliance with future Examinations and set forth the changes Neighborhood will adopt to ensure effective and complete facilitation and assistance in future Market Conduct Examination.

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Appendix A

Information Data Requests

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>

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
3	October 11, 2019	<p>For each of the networks (and network tiers, if applicable) listed under request #2 (2019 networks only),</p> <ol style="list-style-type: none"> 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. 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 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.
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> <ol style="list-style-type: none"> Provider Name Provider NPI 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. Provider Address including Zip Code (actual location where services are provided to members)** Provider County Provider Telephone Number Type of Provider as defined under Rhode Island Regulation 230-RICR-20-30-9.3 (23) Provider Specialty

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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"> 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> <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, 17.1 and 18.1	August 14, 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, 17.2 and 18.2	August 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, 17.3 and 18.3	September 4, 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

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
Email Request Associated with 4.3, 17.3 and 18.3	September 23, 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>
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

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<p>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> <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 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.
6.2	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.
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 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.
8	October 11, 2019	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.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		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.
8.1	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.
9	October 11, 2019	For each of the networks listed under item #2, provide the corresponding member handbooks and evidence/certificates of coverage including the schedule of benefits. The Period that applies to this request is January 1, 2019 through December 31, 2020.
10	October 28, 2019	Provide the Company's complaints and grievances logs maintained during the Period. The log or report should contain the following information: <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 The Period that applies to this request is January 1, 2019 through August 31, 2019.
10.1	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.
10.2	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.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
10.3	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.
10.4	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.
10.5	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.
10.6	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.
10.7	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.
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 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>
11.1	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.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
11.2	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.
11.3	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.
11.4	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.
12	October 11, 2019	<p>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:</p> <p>Address and monitor its population needs that all covered services for beneficiaries, 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, 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>
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.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<p>c. 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.</p> <p>d. In reference to all new networks that will be introduced during 2020, please provide a response to inquiries a. and b. above.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019 and calendar year 2020.</p>
13.1	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.
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>
14.1	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.
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>

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
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	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.
16.2	February 21, 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.
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 <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>

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		The Period that applies to this request is September 1, 2017 through August 31, 2019.
17.4 (17.1-17.3 are stated under request 4 above)	November 13, 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.
Email regarding IDR 17	November 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.
Email Regarding Company's Response to Email above	November 30, 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.
Email regarding revised claims data	December 22, 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.
17.4	January 8, 2021	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	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: <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

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IDR #	Due Date -- as soon as possible but no later than the date noted within each request	Description
		<p>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 v. Denial code w. Denial reason x. Date denied y. Date explanation of benefits mailed</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. 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>
Email regarding IDR 18	November 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.
Email Regarding Company's Response to Email above	November 30, 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
Email regarding revised claims data	December 22, 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.
18.4	January 8, 2021	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>
19.1	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	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> <ol style="list-style-type: none"> Product/Plan name Reason for request Outcome (approved or denied) Percent of coverage (e.g., 100%, 50%, 0%, etc.) Service or procedural code requested Specialty of Provider requested NPI Provider address including zip code Provider county

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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.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>
20.1	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.
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.
20.3	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.
21	October 11, 2019	<p>Please provide the policies and procedures demonstrating that network plan beneficiaries have access to a provider in the event that the plan 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 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.
21.2	December 23, 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.
21.3	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.
21.4	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.
21.5	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.
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.
22.2	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.
22.3	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 <i>Excel</i> listing of all professional provider credentialing or re-credentialing

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<p>activities during the Period, which should include the following data fields:</p> <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	January 27, 2021	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.
23.3	January 27, 2021	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.
23.4	February 23, 2021	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.
23.5	February 23, 2021	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</p>

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		edited documents. Also, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
25	December 31, 2019	<p>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 plan requirements to Optum Behavioral Health ("Optum").</p> <p>Please provide the following documents and/or additional information:</p> <ol style="list-style-type: none"> 1. Copy of the delegation agreement entered into between the Company and Optum. 2. Please explain how the Company ensures through supervision and monitoring controls that Optum is performing the delegated functions in accordance with the agreement for network adequacy and the provider directory. 3. Copies of all quarterly Network Adequacy Geo-Access reports and other network adequacy documentation provided by Optum to the Company during the exam Period. If no reports were provided, did the Company require the quarterly reports as part of its oversight responsibility? If the Company did not require the quarterly reports, please explain. 4. A listing of all provider directory related reports provided by Optum to the Company that allows NHPRI 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 Optum, please explain. 5. A listing of reviews performed by NHPRI to ensure that provider directory and network adequacy functions delegated to Optum 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. 6. A listing of all network adequacy and provider directory quality review reports provided by Optum to the Company during the exam Period. Please explain how the Company used these reports to improve

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		the quality of services provided by Optum. Please provide an example of each report. If the Company did not require any reports from Optum, please explain.
26	December 31, 2019	The following requests pertain to information discussed during the Optum provider directory and network adequacy interviews conducted by RRC on December 17, 2019. Please provide the following:
IDR 27 – January 27, 2021		1. The reports from Optum to the Company regarding Single Case Agreements with out-of-network providers for the Period.
		2. The quarterly business review reports, agendas, meeting minutes or other documentation related to updates regarding provider directory, network adequacy and provider credentialing activities provided by Optum to the Company during the Period.
		3. The script that is utilized to conduct the secret shopper review.
		During the interview, Optum noted that claims for a terminated provider would be processed at the in-network benefit level for 90 days following the termination date. Please provide the policy and procedures in effect during the Period that support the statement noted above
		27.a) If a state such as RI has specific state mandated benefits that can only be provided by a certain type of provider or specialty, would that mandate be considered during the network adequacy and accessibility monitoring to ensure that the benefit is available from an in-network provider licensed and/or certified to offer that service? 27.b) Explain how RI state mandated benefits are considered in the network adequacy and accessibility monitoring process. 27.c) Provide any supporting policies relevant to items 27.a and 27.b.

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Appendix B

Excluded Procedure Code Classifications

I. Introduction:

In response to Information Data Requests (IDRs) 17 and 18, the Carrier provided a separate Microsoft Excel documents listing all zero paid approved claims as well as all adjudicated approved and denied claims. The claims selected for review 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.

On December 12, 2021 Neighborhood Health Plan of Rhode Island ("Neighborhood") submitted its fourth set of claims data as the Examiners found that the initial submissions from delegates Optum Behavioral Health (OBH) and Beacon Health Strategies (Beacon) had accuracy and completeness problems with completeness in the Network Status field.

From this fourth version of six Excel spreadsheets, the Examiners selected claims for services rendered during the Exam Period September 1, 2017 through August 31, 2019. These were consolidated into a unified data model in Microsoft Power BI, which resulted in 1,552,532 claims, 1,447,894 with procedure codes. 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 646,419 codes remained:

- 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

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The Examiners then narrowed the claims data to only 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 122,956 procedure code claims were analyzed as noted below.

B. Procedure Codes Analyzed

From the remaining 122,956 procedure coded claims, as shown in Tab 2 of Neighborhood Procedure Code Table 1 No Dx, 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. Neighborhood Procedure Code Table 1 No Dx, Tab 3 identifies the remaining 98,191 professional procedure claims, which were then analyzed by the Examiners to assess network inadequacies, as presented in the market conduct examination main report ("MCE"). The Examiners then reviewed the claims analyzed in Neighborhood Procedure Code Table 1 No Dx Tab 3 to identify related diagnoses. Neighborhood Procedure Code Table 2 With Dx, Tab 1 shows diagnoses with at least 6 OON claims representing 64,203 claims. These claims were further analyzed as shown on Neighborhood Procedure Code Table 2 With Dx Tab 3 to provide diagnostic detail on network inadequacies, as identified by the Examiners in the MCE report.

III. Methodology to Analyze Claims Identified by Revenue Code

A. Initial Revenue Code Filters.

Neighborhood submitted six Excel spreadsheets for the Data Period referenced above segmented on these excel spreadsheets by paid or denied for Neighborhood, Beacon and Optum. These were consolidated into a unified data model in Microsoft Power BI, which resulted in 1,552,532 claims. The Examiners then selected only the claims with a valid Revenue Code which resulted in 538,983 claims. The Examiners then applied additional filters to include only those claims with Revenue Codes where at least 25 claims were out-of-network and removed any claim with revenue codes similar to the services excluded in Section IIA above. This resulted in the analysis of 64,759 revenue code claims.

B. Revenue Codes Analyzed.

Neighborhood Revenue Code Table 1 No Dx, Tab 3 presents 64,759 revenue coded claims which were analyzed by the Examiners to identify network inadequacies, as presented in the MCE report. The Examiners further analyzed the claims in Neighborhood Revenue Code Table 1 Tab 3 related diagnoses. The Examiners applied a filter to analyze only related diagnoses that resulted in at least 6 or more out-of-network claims. Neighborhood Revenue Code Table 2 With Dx Tab 2 identifies the 9,485 related diagnoses claims that were analyzed. These 9,485 Table 2 revenue code claims were then used to provide diagnostic detail on network inadequacies as identified by the Examiners in the MCE report.

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Appendix C

Professional and Facility Procedure Data

Pursuant to R.I.G.L. 27-13.1-5, the information contained in the Professional and 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 D

Revenue Code Data

Pursuant to R.I.G.L. 27-13.1-5, the information contained in the Revenue Code 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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Wherefore, it is hereby ORDERED:

- A. The Commissioner hereby adopts the Examination Report and Recommendations.
- B. Neighborhood shall report to the Commissioner on July 01, 2023 regarding the implementation of all recommendations in this report.
- C. Neighborhood shall provide a compliance audit and other such information as reasonably requested by the Commissioner.
- D. In lieu of a penalty, Neighborhood shall make a financial investment into the Rhode Island doula workforce community in the total amount of \$75,000.00. The investment dollars shall be used to support Rhode Island doula workforce development and training. Further, as Neighborhood determines areas in need of investment, Neighborhood 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 \$75,000.00 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 Neighborhood's cost of implementing this Report's Recommendations and Orders.
- E. Within 30 days of the issuance of this Order, Neighborhood shall file with the Commissioner affidavits executed by each Director of Neighborhood stating

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

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. Neighborhood 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 Neighborhood Health Plan of Rhode Island

- I. Neighborhood understands and agrees that this Order constitutes valid obligations of Neighborhood, legally enforceable by the Commissioner.
- II. Neighborhood waives its right to judicial review with respect to the above-referenced matter; provided, however, Neighborhood shall have a right to a hearing on any charge or allegation brought by OHIC that Neighborhood failed to comply with, or violated any of its obligations under this Order, and Neighborhood shall have the right to appeal any adverse determination resulting from such charge or allegation.
- III. Neighborhood 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:

2/18/2022

Title:

President and CEO