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

April 12, 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 (MCE) 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 Tufts Insurance Company and Tufts Associated Health Maintenance Organization. Other Examination Reports address compliance by the other carriers.

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

Emily Maranjian, Esq.
RI Office of the Health Insurance Commissioner

Victor Woods, Health Economic Specialist
Office of the Health Insurance Commissioner

On this 12th day of April, 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 12 day of April, 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

ROSANNE M PASQUALE
Notary Public, State of Rhode Island
My Commission Expires Apr. 09, 2025

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 Carrier networks and the accuracy of Carrier Provider Directories. Such compliance is paramount to ensuring the Carrier's beneficiaries have timely access to covered health care services without delay.

This examination report addresses findings of non-compliance and/or non-compliant practices of THP and its delegate Connecticut General Life Insurance

Company also known as Cigna (Delegate). THP delegated certain Network Adequacy and Provider Directory responsibilities to this Delegate in connection with its CareLink plan(s). This examination report does not purport to identify every instance or practice of non-compliance relative to Network Adequacy and accuracy of Provider Directories during the Exam Period[1]. 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 beneficiary[2], a beneficiary's authorized representative or a provider can seek timely resolution of written and oral complaints. As set forth in R.I.G.L. § 27-18.8-2 (8) and 230-RICR-20-30-9.3 (A) (9), a "complaint" or "grievance" means an oral or written expression of dissatisfaction by a beneficiary, authorized representative or provider. According to these provisions the grievance and complaint process (hereinafter, the Complaint Process) must include: resolution of grievances or complaints

[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

(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.

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 instructions[3] 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-20-30-9.5 (B) and 230-RICR-20-30-9.6 (E), to develop, implement and maintain a quality assurance program that provides oversight of all their activities, whether delegated or not. This required ongoing oversight includes processes to regularly evaluate carrier activities (e.g., maintaining an accurate Provider Directory, maintaining an adequate professional and facility provider network, compliant complaint management, and ensuring behavioral health (BH) parity), and determine whether these carrier's activities are being performed in a manner that

[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.

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.

C. Behavioral Health Parity. Carriers are required to provide coverage for BH disorders[4] at parity with medical-surgical (M/S) services according to 42 U.S.C. § 300gg-26, 45 CFR 146.136, 45 C.F.R. § 146.136 (c) (4) (ii) (D), R.I.G.L. § 27-38.2-1 (a) (c) & (d) and 230-RICR-20-30-9.6 (F). These rules specify that carriers shall not impose non-quantitative treatment limitations for the treatment of BH disorders unless the processes, strategies, evidentiary standards or other factors used in applying non-quantitative treatment limitations[5], as written and in operation, are comparable to and applied no more stringently than the processes, strategies, evidentiary

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[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."

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 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 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 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 monitors 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 resolve any deficiencies that limit a beneficiary's ability to access covered services in a timely manner.

G. Maintenance of Accurate and Complete Provider Directories. A carrier is obligated to maintain its Provider Directories as set forth in R.I.G.L. § 27-18.8-3 (c) (4) (i)-(iv) and 230-RICR-20-30-9.7 (D) (2), which require the carrier to make its directories easily accessible to consumers and providers in an accurate, understandable and reasonably comprehensive format. Further, Regulation 230-RICR-20-30-9.7 (D) (4) stipulates that electronic and paper Provider Directories must be updated at least monthly and that daily updates must be available telephonically. Minor changes to provider information, to include address changes and a provider's tax identification number (TIN), must be made within seven business days in accordance with R.I.G.L. § 27-18-83 (b) and 230-RICR-20-30-9.8 (A) (3) (b). Compliance with these provisions ensure that relevant Provider Directory information is up to date so as not to

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

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

H. Credentialing and Re-credentialing. R.I.G.L. § 27-18-83 and 230-RICR-20-30-9.8 set forth carrier requirements for credentialing and re-credentialing professional providers. R.I.G.L. § 27-18-83 (a) and 230-RICR-20-30-9.8 (A) (3) (a) require a carrier to issue its decisions regarding the credentialing or re-credentialing of a professional provider as soon as it is practicable, but no later than 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 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 MCE's.

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 has deemed appropriate.

   B. The Examination targeted two areas of regulatory compliance (more detail is provided in the Information Data Request (IDR) documents which appear as items 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;

b. The carrier's provider credentialing/re-credentialing policies and its 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) is sufficient in scope and in volume;

e. Carrier policies and procedures used to assess and monitor that it is meeting its population's 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 inadequacies in the Carrier's network;

g. The carrier's ability to demonstrate that network plan beneficiaries have access to OON providers in the event that

the plan fails to maintain sufficient provider contracts or an INN provider is not available to provide covered services in a timely manner; and

h. Review of Carrier complaint and grievance logs.

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

i. Professional and Facility Claims using Procedure Codes (Procedural Code Tables 1 and 2 in Appendix C); and

ii. Facility Claims using Revenue Codes (Revenue Code Tables 1 and 2 in Appendix D).

4. The Examiners note that, while this examination was not initially designed to determine compliance with state laws and regulations around Complaint Processes, in the course of reviewing the THP complaints and THP Complaint Processes for the purpose of assessing the adequacy of THP'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, impacting the Examiners' ability to assess Network Adequacy and Provider Directory accuracy.

Summary of Findings and Recommendations

Complaints and Grievances Findings

5. The Examiners reviewed THP's Complaint Processes and Complaint Log[6], 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 THP's responses to any Provider Directory or Network Adequacy issues. This review led the Examiners to assess whether THP's Complaint Processes were compliant with Rhode Island law. The Examiners' findings and conclusions are as presented in Paras. 6-8 herein.
6. The Examiners reviewed THP's response to IDR 10, IDR 10.3 and a follow-up 9/22/20 email from THP regarding the tracking and processing of all complaints. Based on this review the Examiners concluded that THP does not track what it describes as informal member complaints for reporting complaints and grievances. In this email THP states that its "Member Service Representatives are trained to identify an individual's oral or written dissatisfaction/complaint as a potential grievance and offer the member the option to file a formal grievance if the member doesn't ask. If the member would like to file a grievance, the Member Services Representative will document the call as a 'grievance' and transfer the information to the Appeals and Grievance Department for processing and tracking of formal complaints/grievances. Member Services Representatives

[6] References to THP Complaint Log in this report refer to the documents submitted by THP in response to IDR 10.0 entitled "IDR 10 Grievance Log 1.1.19 to 8.31.19 with OHIC complaints and state of residence".

are trained to consider any complaint a formal complaint worthy of the grievance process." If a member does not want to file a complaint, THP further states that "Member Service Representative still documents the discussion from the call in the member's call record notes/narrative. However, as noted previously in the response to IDR 10.3, these type of calls are considered inquiries and only tracked at high-level topic categories." THP did not submit evidence of a complaint process that tracks all member and provider communications of dissatisfaction as defined and required by Rhode Island statute and regulations.

7. THP's response to IDR 10, IDR 10.3 and a follow-up 9/22/20 email from THP regarding the tracking and processing of all complaints did not evidence that its Delegate defined provider complaints in accordance with Rhode Island rules. The Examiners conclude that THP did not evidence that its Delegate forwarded to THP all provider communications of dissatisfaction to enable THP to accurately and effectively process, log, track and report all provider complaints according to Rhode Island rules. THP also did not evidence adequate oversight of applicable provider complaints received by its Delegate to ensure compliance with Rhode Island statutes and regulations.
8. Conclusions of Law. Based on the findings in Paras. 6-7, THP and its Delegate do not define, process, log and report complaints to the extent required by R.I.G.L. § 27-18.8-2 (8), 230-RICR-20-30-9.3 (A) (9), R.I.G.L. § 27-18.8-6 and 230-RICR-20-30-9.6 (A) (4). There is not sufficient evidence that THP and its Delegate has a complaint definition and Complaint Process that captures processes and reports all member and provider expressions of dissatisfaction.

Subsequently, THP and its Delegate did not provide the Examiners with Complaint Logs that include all member and provider communications of dissatisfaction. THP also did not adequately implement and maintain a quality assurance program that included oversight of all its Delegate Complaint Processing activities as set forth in R.I.G.L. § 27-18.8-3 (b) and 230-RICR-20-30-9.6 (E). The Examiners were unable to accurately determine the volume of member and provider concerns regarding Network Adequacy and/or Provider Directory due to the potential underreporting of complaints by THP.

Complaint Recommendations

9. Regarding THP's practices found by the Examiners to be non-compliant, as described in Paras. 6-8, THP shall implement each Complaint Recommendation set forth in Paras. 11-14 by September 1, 2022.
10. Regarding THP's delegate's practices found by the Examiners to be non-compliant, as described in Paras. 7-8, THP shall implement a plan of correction acceptable to the Commissioner relative to each Complaint Recommendation set forth in Paras. 11, 13, and 14 with regard to delegated activities. On or before August 1, 2022, THP shall submit this plan of correction to the Commissioner, which plan of correction shall include implementation dates acceptable to the Commissioner.

11. Establish Rhode Island specific policies and procedures[7] to identify, manage and process complaints, establishing the following:
    A. Revision of the 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 logging, processing and reporting of all THP complaints and applicable delegate complaints shall be defined and processed in accordance with R.I.G.L. § 27-18.8-2 (8), 230-RICR-20-30-9.3 (A) (9) and 230-RICR-20-30-9.6 (A) (1-4). This shall include a procedure to log and categorize complaints consistent with OHIC's reporting instructions and guidance.
    C. Revise processes to require that complaints received by THP from different areas in and outside of THP (e.g., applicable delegates, Consumer and Provider Service Representatives and Complaint and Grievance staff, RIREACH, OHIC, and other state and federal agencies) are properly categorized and compiled as complaints and reported to OHIC consistent with its reporting instructions.
12. THP shall create a Rhode Island specific training manual and a training process for Consumer and Provider Service Representatives and other staff members at THP that receive and/or manage complaints. This training shall include the implementation of the Rhode Island specific policies and procedures noted in

[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.

Para. 11. THP shall provide such training upon any material revision of policies and procedures and on a periodic basis no less than annually.

13. THP shall establish a Rhode Island specific audit process to periodically monitor the activity of its and its delegates' Consumer and Provider Service Representatives and other staff involved in complaint receipt and processing to evaluate compliance with revised complaint policies and procedures.

14. THP 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. THP shall prepare and submit a report to OHIC by May 31, 2023, which shall identify the complaints received by it and any delegate relating to Network Adequacy and Provider Directory issues during October 1, 2022, through April 31, 2023. This report shall further convey how THP incorporated complaint information into its periodic monitoring and assessment of its Network Adequacy and Provider Directory accuracy

Provider Directory Findings and Conclusions

15. The Examiners reviewed THP'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 THP staff on January 6th and 17th, 2020 (hereinafter "Interviews"), to evaluate the accuracy of THP's Provider Directory. The Examiners findings and conclusions are set forth in Paras. 16-23.

16. In response to IDR 6, which requested information about procedures for updating Provider Directories, THP produced a document titled "Provider Data Changes in

Systems and Provider Directory 2019" which stated "When the Provider Information (PI) department receives new and/or updated information from providers, the PI department will implement the change in internal systems within five business days of receipt of such information. The provider directory will then be updated within two business days of the change in systems, which allows for information to feed from internal systems to the vendor that publishes our provider directory. The provider directory is updated nightly." THP's response to IDR 6.4 further describes THP's relationship with its vendor, HealthSparq, who contracts with THP to update its online Provider Directory. In this IDR response THP stated that "Once the provider information area has completed processing provider data, the information is available in internal systems. As previously stated, files are sent to HealthSparq daily, which include any provider data updates. As the department policy turnaround time for updating the data and the submission to HealthSparq are all completed within the first two weeks of the month, updates are made, and visible on the on-line search well within the month requirement." THP did not provide the Examiners with enough information to evaluate when daily telephonic updates are provided to beneficiaries and consumers.

17. Conclusions of Law. Based on the findings in Para.16, THP did not substantiate whether it complies with the Rhode Island rules that require daily Provider Directory updates are available telephonically, as set forth in R.I.G.L. § 27-18.8-3 (c) (4) and 230-RICR-20-30-9.7 (D) (4).

18. In IDR 7 the Examiners requested that THP provide policies, procedures, flow charts and a summary explanation to evidence its controls for validating the information in its Provider Directory. In response, THP provided a document titled "Provider Data Changes QC Process" that states "Tufts Health Plan's Provider Information department performs a complete review of 100% of new provider enrollments into internal systems by comparing the source documentation to the data that has been entered in the main system. Any errors discovered are corrected and errors are recorded and tracked for training purposes." The Examiners noted that within THP's IDR 23 response document titled "IDR 23 Provider Credential Activities" a total of 26 new Rhode Island providers were credentialed in February and 66 Rhode Island providers were credentialed in July. In follow up, the Examiners reviewed THP's response to IDR 25.1 which requested THP's February and July 2019 documents to support THP's statement that its "Provider Data Changes QC Process" reviews 100% of its Rhode Island providers credentialed during those months. The Examiners found that the February 2019 quality review data provided by THP did not include any Rhode Island providers with errors in their provider directory information, and the July 2019 data only included one Rhode Island Provider with error(s) in the provider directory information. Although THP's QC process includes validating the accuracy of all new providers credentialed, there is not sufficient documentation that THP conducted a quality review of 100% of its newly enrolled providers as stated in THP's responses to IDR 7 because only error information is documented during the QC process and no further information was provided during the Interviews with THP's Provider Information Department on

January 6, 2020.THP's response to IDR 7 provided a document titled "Tufts Health Plan Provider Information Department Quality Review Process" that also notes the following: "On a weekly basis, 10% of any changes or updates are reviewed to ensure all associated information has been updated correctly." In response to IDR 25.2, THP submitted the requested sample selection methodology and documentation to support the completion of these reviews for Rhode Island providers conducted during March 2019 and August 2019. The documents submitted were spreadsheets titled "March 2019 ETR Audit", "August 1-18 ETR Audit", "August 25 Audit" and "September 1 ETR Audit". In this response THP stated "The reports represent the 20% sample of electronic transactions for the week, and the yellow highlighted completed lines consist of any errors found and when they were corrected." Though THP's response to IDR 7 and IDR 25.2 present two different sampling data points (10% and 20%), the Examiners reviewed these spreadsheets within IDR 25.2 to reveal tabs labeled: Pcat Switches, IPA Switches, Adding Additionals, Termed Additionals, Restrictions, Market Indicators, PCP W Addl IPAs, Review Pcat-TOP, Review Specialty Code, Missing Gender, Missing DOB, Missing NPI, Missing Specialty, Review Address Flags, Missing # and Misspelled City Name. Examiners were unable to assess whether a sufficient number of Rhode Island providers were included in this network directory audit given that most of the tabs in these spreadsheets did not include the location of the provider. The Examiners concluded that IDR 7 documents presented as an audit on the accuracy of its Rhode Island Provider Directory were inadequate.

19. Examiners also reviewed THP's responses to IDRs 7, 7.2, 7.3 and 7.4 regarding the annual Provider Directory accuracy audit. These audits include other states and other lines of business written by THP. THP's response to IDR 7.4 notes the following regarding the Rhode Island providers included in the 2018 annual review submitted within IDR 7.3 titled "2018 Audit Results": "The audit was broader than just Rhode Island providers. Specific to Rhode Island providers, there were 23 providers with 74 Rhode Island practice locations included in the 2018 audit. The specialty types included in the audit were as follows: 1. Family Practice, 2. Internal Medicine, 3. Cardiology, 4. General Surgery, 5. Gynecology, OB/GYN, 6. Neurology, 7. Ophthalmology, 8. Orthopedic Surgery and 9. Pulmonology." The Examiners note that not all provider types were included in the 2018 annual review and there were no BH providers included in this audit.
20. The Examiners issued IDR 25 to THP requesting information regarding THP's Provider Directory quality review reports. As previously noted, THP uses a contracted outside vendor "HealthSparq" to manage its on-line provider search tool which includes functionality to create searches of the Provider Directories that may be emailed or printed. THP provided the following response to IDR 25: "HealthSparq provides daily error reports to Tufts Health Plan (please see example document titled "Error Report.xlsx"). Tufts Health Plan's Provider Information Department reviews the error report and makes any necessary corrections in the internal Tufts Health Plan systems, which would then update HealthSparq via the nightly files that are sent. Please note that the daily error report includes errors across all Tufts Health Plan offerings (which includes some

group specific networks) so not all the errors appearing in the error report are applicable to Rhode Island fully insured plans." The Examiners reviewed the error report example that THP provided. The Examiners were unable to determine how this reported information assisted THP in monitoring the quality of the work performed by its Provider Directory vendor. IDR 25 also included a request for a listing of all Provider Directory quality review reports prepared by THP regarding transactions processed by the Provider Directory vendor during the Exam Period. THP provided the following response: "Tufts Health Plan did not prepare or provide any quality review reports during the examination period."

21. In IDR 3 the Examiners requested electronic copies of THP's Provider Directories for each of its networks, including for the CareLink product. THP and THP's Delegate provided the electronic copies in Excel format. THP and THP's Delegate also informed the Examiners that the Delegate's Provider Directory, the CareLink Provider Directory, appears on THP's website. Its Delegate submits the CareLink Provider Directory information to THP's Provider Directory vendor to allow for display on the THP website. Though the Provider Directory error reports explained in Para. 20 did contain references to the Delegate's CareLink providers, the CareLink provider network does not appear in any of the other quality reviews performed by THP as discussed in Paras. 18-20.
22. The Examiners issued IDR 8 to request internal audits, internal compliance reviews and external audits conducted regarding Provider Directory accuracy and ensuring compliance with Rhode Island state regulations and statutes. THP provided the following response: "Tufts Health Plan did not conduct an internal

audit or internal compliance review of provider directory accuracy and ensuring compliance with Rhode Island state regulations and statutes during the requested time period. Tufts Health Plan does monitor provider directory accuracy and access through processes as described in responses to IDR #'s 6, 7, 14, 15, and 16. As a NCQA accredited entity, Tufts Health Plan maintains documentation to meet NCQA requirements. Certain elements captured in monitoring activities addressed in other responses are reviewed as part of Tufts Health Plan's NCQA accreditation. During the last NCQA review applicable for Tufts Health Plan commercial product, there were no findings related to provider directory standards." Based on this THP response, the Examiners issued IDR 8.1 further clarifying its request that it was also seeking the most recent internal audits, internal compliance reviews and external audits conducted by THP, even if after the targeted time period of the examination. THP's initial response to IDR 8 stated, "Tufts Health Plan did not conduct an internal audit or internal compliance review of provider directory accuracy and ensuring compliance with Rhode Island state regulations and statutes during the requested time period."

23. Conclusions of Law: Based on the findings in Para. 22 THP's quality assurance program, for assuring the accuracy of THP's Provider Directories, for the Exam Period did not fully comply with the requirements as stated under R.I.G.L. § 27-18.8-3 (b), 230-RICR-20-30-9.6(E) and 230-RICR-20-30-9.5(B)(1). THP did not evidence regular and meaningful oversight of the accuracy of its Delegate's Provider Directories.

Provider Directory Recommendations

24. Regarding THP's practices found by the Examiners to be non-compliant, as described in Paras. 16-23, unless otherwise specified, on or before January 1, 2023, THP shall implement each Provider Directory Recommendation set forth in Paras. 26-30.

25. Regarding THP's delegate's practices found by the Examiners to be non-compliant, as described in Para. 21 and 23, THP shall implement a plan of correction acceptable to the Commissioner relative to each Provider Directory Recommendation set forth in Para, 26 as applicable. On or before August 1, 2022, THP shall submit this plan of correction to the Commissioner, which plan of correction shall include implementation dates acceptable to the Commissioner.

26. Establish Rhode Island specific policies, procedures and processes to assess Provider Directory accuracy and ensure the correction of deficiencies to include the following:

    A. Documentation establishing timelines for the updating of Provider Directories including, without limitation, a Provider Directory database capable of supporting the requirement that updates be made available daily upon request telephonically;

    B. Policies to ensure that employees responsible for responding to telephonic inquiries for Provider Directory information have access to and utilize data sources that contain information that is updated daily; and

    C. A revised process for evaluating and auditing the accuracy of its Provider Directories and correcting identified deficiencies. This process shall

include at a minimum: periodic direct communication with INN providers to audit directory accuracy; auditing of a comprehensive number of providers and provider types, to include BH providers; mechanisms for measuring Provider Directory accuracy across all provider types; the systematic use of data-driven information (e.g., claims, complaints, inquiry logs, credentialing, contracting) to inform and evaluate directory accuracy and compliance; and mechanisms to correct identified inaccuracies and improve upon directory error rates.

27. THP shall establish an ongoing audit mechanism for any and all delegates and contracted vendors responsible for Provider Directory updates to evaluate compliance with R.I.G.L. § 27-18.8, 230-RICR-20-30-9.5 (B) (1), and the associated Recommendations issued in this Examination report.
28. THP shall create a Rhode Island specific training manual and a training process that incorporates the revised policies and procedures noted in Para. 26 and provide necessary ongoing training for staff whenever policies and procedures are materially revised and on a periodic basis no less than annually.
29. On or before August 1, 2022, THP shall conduct a Rhode Island specific Provider Directory audit in accordance with Para. 26 (C) and provide OHIC with the report summarizing and certifying that this audit was conducted in accordance with Para. 26 (C) as well as setting forth the results of the audit and THP's plans for addressing any identified deficiencies revealed in the audit.
30. On or before August 1, 2022, THP shall submit to the Commissioner for approval a plan for a master data management solution that consolidates disparate

provider information received by THP and its delegates and enables THP to create a single source of up-to-date INN Provider Directory information.

Network Adequacy Findings

31. The Examiners reviewed THP's responses to the IDRs identified in the below paragraphs (the specifics of each initial IDR request can be found in Appendix A) as well as the Interviews conducted with THP staff. The Examiners findings, conclusions and statements of concern are as stated in Paras. 32–55.

32. The Examiners issued IDR 12.1 requesting documentation to determine if THP monitors and assures that its provider networks are sufficient in scope and volume for all its beneficiaries to include children and adults with serious chronic and/or complex health conditions or physical and/or mental disabilities and persons with limited English proficiency and that these networks are accessible in a timely manner without unreasonable delay. THP supplied the following response: "Tufts Health Plan utilizes the essential community providers (ECPs) network adequacy template developed by the federal government to monitor access to ECPs." After the Examiners reviewed THP's complete response which included documents titled "2020 ECP_Network Adequacy Template" and "2020 RI RCP Supplementary Response" they found THP had not submitted documentation or information during the Exam Period sufficient to confirm that it monitors the above categories.

33. Conclusions of Law. Based on the findings in Para. 32, THP's practices are not fully compliant with R.I.G.L. § 27-18.8-3 and 230-RICR-20-30-9.7(A)(1). During the Exam Period THP did not substantiate that it has an ongoing process in place

to specifically monitor that its provider network for some beneficiary groups specifically identified in Para. 32 above are accessible in a timely manner without unreasonable delay.

34. In response to IDR 15 the Examiners requested how frequently THP monitors the adequacy of providers for each network plan. THP provided several responses including the following statement: "On a quarterly basis, Tufts Health Plan completes an appraisal and analysis of its primary care, behavioral health and high-volume high impact specialists[8] which are captured on a tracking grid. Please see the attached workflow which describes this process (file labeled "Rhode Island Quarterly Network Adequacy Requirement Monitoring Report Workflow.pdf")". The Examiners issued IDR 15.1 to THP requesting the quarterly network adequacy reviews performed during 2019. THP provided three 2019 quarterly reports and each report considered the following provider types: cardiologist, gastroenterologist, licensed clinical social worker, licensed mental health counselor, medical oncology, obstetrician gynecologist, neurologist, orthopedic surgeon, primary care, psychiatrist, psychologist, pulmonologist and surgeon. As such, THP's Network Adequacy monitoring for certain facility and provider types did not assess network access for its population of beneficiaries for all covered benefits. The Examiners issued IDR 15.4 asking THP to explain why only certain providers are included in the quarterly adequacy reviews. THP

[8] THP identifies high-volume and high-impact specialty providers, through a biennial analysis of the utilization/claims data and determine the ratios and numerical requirements of contracted providers for THP members including consideration for proximity and accessibility. Actuarial analysis has identified high volume specialists using ETG (episode treatment groups - total cost) and identified that the specialist identified as high volume matched those identified as high impact.

provided the following response: "Tufts Health Plan does not perform a network adequacy analysis that evaluates all providers available within the Rhode Island commercial network, but instead focuses on high impact, high volume providers. Analyses performed for networks outside of Rhode Island are also performed on high impact, high volume provider types as referenced in the Availability and Accessibility Policy & Procedure previously provided in response to IDR 14." As noted in THP's response to IDR 15.4 the list of specialties "will always include OB/GYN and oncology specialists". THP also stated in its IDR 15.4 response that "Additional avenues by which Tufts Health Plan monitors adequacy of its network include out-of-area requests, appeals and grievances related to access and availability, CAHPS surveys and Mental Health Appointment Access surveys, as referenced in response to IDR 15.3". The Examiners also reviewed THP's response to IDR 4[9] and noted that 86 specialists comprise THP's network, however, only 13 specialists are included in THP's network adequacy analysis. During an Interview held with THP on January 6, 2020, the network adequacy analyst stated that OON claims activity and utilization, grievances, appeals, complaints regarding inadequacy of networks and provider appointment wait-times are *not* considered by THP's analyst during the quarterly network adequacy reviews. This interview statement appears to conflict with THP's written response within IDR 15.4.

[9] The documents reviewed within the IDR are titled "IDR 4 Standard Network Providers as of 10- 18-19.xlsx" and "IDR 4 Standard Network Providers as of 10- 18-19 with contracting entity.xlsx"

35. Conclusions of Law. Based on the findings in Para. 34 THP did not have a process in place to sufficiently evaluate Network Adequacy in violation of R.I.G.L. §27-18.8-3 (c)(2) and 230-RICR-20-30-9.7 (A)(1). As such, THP failed to evaluate that it has a network sufficient in scope and volume to deliver timely covered health care services to meet the needs of some beneficiary groups specifically identified in Para. 34 above.

36. The Examiners requested information through IDR 15 regarding the frequency of THP's Network Adequacy monitoring and oversight of its Delegate's regional products for Rhode Island situs plans. THP's Delegate provided the following response: "Please refer to the appropriate sections in PS 8 attached under IDR #12". The Examiners reviewed the Delegate's document labeled "MED PS 8" measuring the availability of providers. The document evidenced that THP's Network Adequacy reviews of these Delegate networks are conducted annually. IDR 15.1 was then issued requesting documentation to support of its Delegate's on-going analysis of the adequacy of provider networks for its Rhode Island situs plans. The Delegate provided the following response: "The reports are formatted by state, zip code, and provider group, e.g., PCPs, pediatrics, high volume specialties cardiology, OB/GYN, etc. Cigna runs standard analyses for all states and specific analyses for some. Attached are the adequacy analyses – reports run from Quest Analytics – including standard reports for CT and NY and CT-specific. Based on the analyses, there were no gaps identified during the exam period." In response to IDR 15.1 THP also provided the following Delegate documents: "Cigna Network Adequacy Analysis CT OAP 2019" and "Network

Adequacy Analysis NY OAP 2019". These documents contained the Delegate's annual network adequacy analyses for its Rhode Island situs plans dated June 2019. Also, during an Interview with THP and its Delegate it was confirmed that only annual network adequacy reviews, and not quarterly reviews, were conducted for the Delegate's networks located in Connecticut and New York.

37. Conclusions of Law. Based on the findings in Para. 36, the Delegate did not conduct quarterly network adequacy reviews for network providers outside of Rhode Island in compliance with the requirements set forth in § 27-18.8-3(2) and 230-RICR-20-30-9.7(B). THP did not maintain regular and meaningful oversight to sufficiently evaluate its Delegate's monitoring of its network outside of Rhode Island and therefore did not comply with R.I.G.L. § 27-18.8-3(b), 230-RICR-20-30-9.5 (B)(1) and 230-RICR-20-30-9.6 (E).

38. IDR 22 requested THP's credentialing and recredentialing policies and procedures. In response, THP submitted a document titled "Policy and Procedure Manual for Credentialing and Recredentialing 2019" . The Examiners reviewed this information and found numerous references to non-compliant timeframes ("60 calendar days") for THP to render credentialing decisions. IDR 22.1 requested clarification regarding this information, and THP responded, "Please note, the section of the 2019 Policy and Procedure Manual for Credentialing and Recredentialing that was previously submitted in response to IDR 22 has since been updated to correct typographical errors. Please see the updated document submitted as part of this response named "Tufts Health Plan Credentialing Policy and Procedure_2019 Updated.pdf" to replace the file that was previously

submitted." While THP did update the submitted document to reference the 45-calendar day timeframe it further stated, "If a credentialing decision is made to deny credentials to a practitioner, the QOCC sends the practitioner written notification of all reasons for the denial within 45-calendar days of receipt of the completed and verified application." Accordingly, THP's policies failed to comply with the statutory requirement to communicate credentialing and re-credentialing decisions within 45-calendar days of receipt of a completed application.

39. The Examiners submitted IDR 23 to THP requesting credentialing and re-credentialing transactions during the Exam Period. THP provided the list of transactions, however, the date the decision was communicated to the provider was not included in the data. THP provided the following response regarding the missing data: "An Excel workbook of Tufts Health Plan provider credentialing activities (see file labeled "IDR 23 Provider Credential Activities.xlsx"). Please note that there are separate tabs for initial credentialing and recredentialing activities within this Excel workbook. THP is unable to populate complete data for IDR 23(i) but has included the workflow specific to the provider notification process (see file labeled "Welcome Letter Workflow 8.2018")". The Examiners reviewed the file labeled "Welcome Letter Workflow 8.2018"; however, this document does not provide the date the credentialing decision was communicated to each provider as stated in the IDR 23 listing. THP subsequently provided the date for a portion of the credentialing applications received during the Exam Period. During the Exam Period, THP received 368 credentialing applications and THP provided evidence that 70 of the decisions were made past

the 45-calendar days and 104 credentialing decisions were made within 45-calendar days. For the remaining 194 providers, THP provided no evidence as to when these decisions were communicated, therefore the Examiners were unable to identify compliance with the 45-day notification requirement for these credentialed providers without the availability of the date the decision was communicated to the providers as required under 230-RICR-20-30-9.8 (A) (3)(a). In terms of re-credentialing transactions, THP received 812 re-credentialing applications and 773 of the decisions were made past the 45-calendar days with the remaining 39 re-credentialing decisions made within 45-calendar days. There was no evidence as to when these decisions were communicated to providers, therefore, the Examiners were unable to identify compliance with the 45-calendar day requirement for all its re-credentialed providers without the availability of the date the decision was communicated to the provider as required under 230-RICR-20-30-9.8 (A) (3)(a).

40. Conclusions of Law. Based on the findings in Paras. 38 and 39 during the Exam Period THP did not substantiate that it communicated credentialing and re-credentialing decisions to providers within 45-calendar days in violation of R.I.G.L. § 27-18-83 and 230-RICR-20-30-9.8 A (3) (a). The Examiners were unable to determine THP's compliance with 230-RICR-20-30-9.8 (A)(3)(a) because THP did not provide the date that the credentialing decision was communicated for a number of its providers.

41. In response to IDR 22 THP's submitted its Delegate's provider credentialing and recredentialing policies and procedures. The Examiners reviewed this

information and determined that THP's Delegate's credentialing policies and procedures for its New York and Connecticut providers do not include Rhode Island requirements for communication to applicants of a credentialing or re-credentialing decision within 45 days.

42. Conclusions of Law. Based on the findings in Para. 41 THP did not evidence that its Delegate's credentialing and re-credentialing policies and procedures for network providers outside of Rhode Island comply with R.I.G.L. § 27-18-83 and 230-RICR-20-30-9.8 (A) (3) (a). In addition, THP failed to implement and maintain an adequate quality assurance program that included regular and meaningful oversight over its Delegate's credentialing and re-credentialing activities for network providers outside of Rhode Island, which is non-compliant with R.I.G.L. § 27-18.8-3(b) and 230-RICR-20-30-9.6 (E).

43. In response to IDR 16 and 16.1 THP submitted, in part, the NCQA methodology it uses to determine the adequacy of its network using appointment time standards. In the IDR 16 response, the Examiners were directed to IDR 24 and a document titled "2019 Commercial Provider Manual". On page 55 of this document THP reveals its time standards for access to M/S services as follows: urgent care to occur within 24 hours of a request, nonurgent symptomatic care within one week of a request and preventive care within 45 days of a request. The Examiners were also directed to IDR 15 to review THP's document titled "Behavioral Healthcare Appointment Access Survey Policy and Procedure" that presents THP time standards for access to BH services as follows: urgent care to occur with 48 hours of a request, initial routine care within 10 business days and

routine follow up within a reasonable timeframe. Examiners note the BH appointment time standards as stated in its Behavioral Health survey appear to be less favorable for beneficiaries than the M/S standards for both urgent and routine care. In addition, the BH appointment standard for urgent care at 48 hours is in excess of the Rhode Island requirement set at 24 hours for all urgent care. In IDR 16.1 THP submitted a document titled "IDR 16.1.2 Specific Standards Chart.pdf" that identifies two levels of BH emergency services with what appears to be associated access standards. In this document, BH emergency services access time standards are "Life threatening needs, immediately" and "Non-life-threatening needs, within 6 hours." For M/S emergency services access time standards are "Emergency care, same day." The Rhode Island access time requirement for both M/S and BH emergency service is that these services be immediately available.

44. In response to IDR 16.1 THP submitted its distance standards in a document titled "IDR 16.1.2 Specific Standards Chart"[10] to present its numeric distribution of its INN providers. For M/S primary care, 2 providers must be available within 15 miles or 15 minutes whereas for both M/S and BH high volume and high impact specialists the access standard is for 1 provider to be available within 30 miles or 45 minutes. There was no distance standard set for BH provider access outside of those defined by THP as high volume and high impact specialists. In contrast,

10 The IDR 16.1 Specific Standards Chart identifies M/S providers as primary care and high-volume, high-impact specialists as OB/GYN, oncology, neurology, orthopedic, cardiology, pulmonary medicine, gastroenterology and surgery providers. On this chart high-volume and high-impact BH providers were identified as psychiatrists, LICSWs and psychologists.

IDR 15.1 contained Network Adequacy Reports Quarters 1-3 of 2019[11]. In IDR 15.1 quarters one and two reports note the distance standard as 2 primary care providers in 15 miles and 1 provider in 30 miles for all other M/S and BH providers with no time limits but quarter three notes 2 primary care providers in 15 miles or 40 minutes[12] and one provider in 30 miles or 45 minutes for all other M/S and BH providers. There was no BH provider availability meeting the less beneficial 2 providers within 15 miles or 40 minutes noting that THP appears to present conflicting information in the time standards among the quarterly reports and between its network adequacy report and its written standards. Finally, though THP identified LMHC in its network adequacy report no written standard was provided by THP for this BH group of providers.

45. Statement of Concern. Based on the findings in Paras. 43 – 44 , THP's network adequacy evaluation documentation appears to be inconsistent with 230-RICR-20-30-14.3 (A) (39) which defines urgent health care services as those which would necessitate treatment within a 24-hour period, however, THP's BH appointment survey evidenced a BH urgent care network access evaluation standard of 48 hours. Based upon Para. 43, the Examiners are concerned that THP's Network Adequacy appointment access standards for urgent care BH services (measured in time), appear to be different than the standards set for M/S urgent care services.

[11] The IDR 15.1 Network Adequacy Report identifies M/S providers as primary care, cardiology, gastroenterology, medical oncology, neurology, OB/GYN, orthopedic surgery, pulmonology and surgery. In this report BH providers were identified as LICSWs, LMHCs, psychiatrist and psychologists.

[12] THP has explained that the time standard is 15 minutes. The analytic software used to run this report erroneously stated the standard as 40 minutes. As the standard is miles or time, and the mileage standard was met, the time input error in the software had no impact on the testing results.

Further, THP's limited number of high-impact and high-volume BH providers included in its network adequacy assessment tools is also different from the more comprehensive listing of high-impact and high-volume M/S providers. Finally, based on the finding in Para. 43, THP's access standard definitions used for BH emergency care are not consistent with the definitions set forth in R.I.G.L. §27-18.8-2 (10), 230-RICR-20-30-9.7(A)(2) and 230-RICR-20-30-9.3(A)(12).

46. In response to IDR 16, THP's Delegate included two policies applicable during the Exam Period for determining the adequacy of its network using appointment time standards. One titled "Med PS_6 Measuring Accessibility of Medical Services" and the second titled "Access To Care and Telephone Standards". A third policy titled "Med PS_6 Measuring Accessibility of Medical and Behavioral Services" became effective 10/22/19 (outside of the Exam Period) combining and replacing these two previous policies. The policies effective during and after the Exam Period reveal the Delegate's M/S appointment time access standard for emergency care as immediate access. The Delegate's BH appointment time standards effective during the Exam Period reveal the following appointment time standards: for life threatening emergency care as immediate access and non-life threatening emergency care within 6 hours. In these policies, THP's Delegate makes the distinction between an emergency and a non-life-threatening emergency when applying appointment wait-time standards to BH emergency care that this does not occur for M/S emergency care. The application of a 6 hour wait-time for any level of a BH emergency is not compliant with the Rhode Island requirements defining immediate access for all emergencies.

47. Conclusions of Law and Statement of Concern. Based upon Para. 46, THP did not comply with 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 its Delegate's activities to include certain access standards in compliance with Rhode Island laws and regulations. Finally, based upon Para. 46, the Examiners are concerned that the Delegate's Network Adequacy standard for non-life threatening BH emergency services are different than the standard set for M/S emergency services.

48. The Examiners analyzed the claims data in Procedure Code Table 1, Tab 2 (Appendix C). The Examiners reviewed the combined professional and facility procedure code claims data. Tab 2 of this table includes 190,278 professional and facility procedure code claims with 149,987 (78.8%) of these claims identified as M/S, 29,000 (15.6%) identified as BH and 10,591 (5.6%) identified as Shared Health services (SH)[13]. Of the total procedure code claims analyzed, 16,935 (8.9%) were identified as OON, with 11,117 (65.6%) of the total OON claims identified as M/S OON claims, 4,021 (23.7%) as BH OON claims and 1,797 (10.6%) as SH OON claims. The following categories of services had more than 10% rendered OON: urgent services, 24-hour facilities, ophthalmic exams, osteopathic and chiropractic manipulative therapies, office outpatient, psychotherapy (individual and group), community support services, inpatient and outpatient alcohol and substance use detox/residential programs and partial

[13] Shared claims (SH) are those coded claims that could be for M/S or BH services. The SH within this examination include: Emergency Services, Clinic, Urgent Care Clinic, Outpatient Office Visits, and Professional Fee/ER claims.

hospitalization services. (Appendix C, Procedural Code Table 1, Tab 2). The Examiners note that THP approved an average of 67.2% of all OON claims.

49. The Examiners further analyzed the claims data identified in Para. 48 to determine what specific diagnostic categories were linked to these M/S, BH and SH OON claims. Procedure Code Table 2, Tab 4 provides more diagnostic detail on the OON claims found in Procedure Code Table 1, Tab 2 after filtering the claims to only include diagnostic categories with at least 6 OON claims (more detail provided in Appendix B). Upon review of the 74,336 filtered procedure code claims (INN and OON) found in Procedure Code Table 2, Tab 4, the Examiners identified 51,001 (68.6) as M/S, 21,254 (28.6%) as BH and 2,081 (2.8%) as SH. Of the total procedure codes analyzed in Procedure Code Table 2, Tab 4, 10,983 (14.8%) were identified as OON claims, 6,796 (61.9%) of which were M/S OON claims, 3,696 (33.5%) of which were BH OON and 511 (4.7%) of which were SH. The Examiners then broke down these "6 or more" OON claims by diagnoses to reveal the following diagnoses: muscular and back pain for manipulative services; major depression, anxiety, and adjustment disorders for psychotherapy services; and cardiac, hypertension, respiratory, BH, diabetes, cough, pharyngitis for office visits. Of the total MS, BH and SH OON claims identified in Procedure Code Table 2, Tab 4 67% were approved. See Procedure Code Table 2 in Appendix C for additional information to support these findings.

50. Based on the data analysis of procedure code claims described in Paras. 48-49 and the additional data analysis detailed in Procedural Code Tables 1 & 2 (Appendix C), the Examiners found that this claims data indicated the need to

further evaluate potential for network inadequacies. Though OON services were approved at a high rate it is important to determine if these high OON rates reflect consumer choice to use their out-of-network benefits or indicate 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 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.

51. The Examiners analyzed, filtered and sorted the claims data in Revenue Code Table 1 (Appendix D). Tab 3 of this table shows a total of 32,981 revenue-code-based facility claims, with 16,767 (50.8%) of these claims identified as M/S claims, 3,107 (9.4%) identified as BH claims and 13,107 (39.7%) as SH claims. Of the total revenue code-based claims analyzed, 2,715 (8.2%) were identified as OON, 1,065 (39.2%) of which were M/S OON claims, 834 (30.7)% of which were BH OON claims and 816 (30.1%) of which were SH claims. Of the total BH revenue code-based claims, 26.8% were OON, whereas 6.4% of the total M/S revenue code-based claims were OON and 6.2% of the total SH revenue code-based claims were OON. An average of 77.9% of all OON claims were approved.

52. The Examiners analyzed the claims identified in Para. 51 to determine what specific diagnostic categories were linked to M/S, BH and SH 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 5 OON claims. The total number of revenue code-based claims analyzed in Revenue

Table 2, Tab 2 was 5128, with 1,762 (34.4%) identified as M/S claims, 1,555 (30.3%) identified as BH claims and 1,811(35.3%) identified as SH claims. Of the total revenue code-based claims analyzed in this table, 1,549 (30.2%) were identified as OON claims, 448 (28.9%) of which were M/S OON, 809 (52.2%) of which were BH OON and 292 (18.9%) of which were SH OON. A breakdown of the diagnoses associated with these OON revenue code-based claims reveals that emergency services for a number of diagnoses (17.8% of Tab 2 All OON), physical therapy for various musculoskeletal issues (9.4% of Tab 2 All OON) and substance abuse disorders and major depression at IOP, PHP and residential levels of care (41.8% of Tab 2 All OON) accounted for 69% of all of the OON claims on this revenue code-based claim set. See Revenue Code Table 2 in Appendix D for additional information to support these findings and conclusions. Of all OON claims in Revenue Table 2, THP approved 75.3% of these claims.

53. Based on findings in Paras. 51 and 52 and the additional data detailed in Revenue Code Tables 1 and 2, the Examiners found that the claims data suggested the need to further evaluate network adequacy, and make improvements as necessary, for emergency services, physical therapy and IOP, PHP and residential treatment for substance use and major depression disorder. 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.

54. The Examiners further analyzed the procedure code and revenue code claims tables (Appendices 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 4.2% and as a percentage of total OON procedure code claims it was 34.8%. The Examiners also found that 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 4.7% and as a percentage of total OON revenue code claims it was 23.4% (Revenue Table 2 Tab 3 for this data summary). The Examiners concluded that THP has an overall OON denial rate that indicates a significant majority of OON services are paid for and therefore clinically necessary covered benefits. However, OON services paid for by THP does not always protect the beneficiary from balance billing by the OON provider beyond what the beneficiary is liable for INN. In addition, beneficiaries may either not seek care or delay care due to the potential for additional financial risk of obtaining care from an OON provider.

55. Statement of Concern. Based on the findings in Paras. 48-54, the Examiners note their concern that THP may need to improve certain aspects of its assessment of network adequacy as its membership expands in the Rhode Island market[13].

[13] THP noted that it is a regional health plan, with a primary service area in Rhode Island, Massachusetts, New Hampshire and bordering parts of Vermont, Connecticut and Maine. Almost half of THP's Rhode Island members are enrolled in PPO plans with out-of-network benefits.

Network Adequacy Recommendations

56. Regarding THP's practices found by the Examiners to be non-compliant, as described in Paras. 32-56, unless otherwise specified, on or before September 1, 2022, THP shall implement each Network Adequacy Recommendation set forth in Paras. 58-64.

57. Regarding THP's delegate's practices found by the Examiners to be of concern or non-compliant, as described in Paras. 36-37, 41-42, THP shall implement a plan of correction acceptable to the Commissioner relative to each Network Adequacy Recommendation set forth in Para 58, as applicable to delegated activities. On or before August 1, 2022, THP shall submit this plan of correction to the Commissioner, which plan of correction shall include implementation dates acceptable to the Commissioner.

58. Establish the following revised Rhode Island specific policies, procedures and processes that are to include the following:

    A. A revised policy and mechanism to evaluate whether its network is sufficient in volume and scope, such that its beneficiaries can access 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 relevant provider and consumer data to evaluate and then actively initiate efforts, as necessary, to address identified network deficiencies. This policy shall also include a process to identify and document the reasons for any identified network deficiencies and THP's efforts to resolve such deficiencies.

B. A revised process to conduct its quarterly reviews of its Network Adequacy activities, to include review of its delegate's Network Adequacy activities, in accordance with 230-RICR-20-30-9.7 (B), and to report the results of this quarterly review to the OHIC.

C. A revision of its credentialing and re-credentialing policy and the establishment of a process and an audit mechanism to comply 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 (A) (5), 230-RICR-20-30-9.8 (A) (3) (a) and 230-RICR-20-30-9.8 (D) (1-8).

D. A revision of the policies and procedures for access standards to ensure that the same standards are reasonably applied to BH and M/S providers, including:

i. Time and distance standards;

ii. Provider to patient ratio standards;

iii. Access to appointment standards;

iv. Access to prescribing and non-prescribing provider standards; and

v. Access to emergency services for BH and M/S twenty-four (24) hours a day, seven (7) days a week.

59. Create a Rhode Island specific training manual that includes the revised Rhode Island specific policies and procedures noted in Para. 58 and provide training to the THP staff responsible for determining Network Adequacy, credentialing/re-credentialing and contracting when any policies or procedures are materially revised and on a periodic basis no less than annually.

60. Develop a plan to evaluate and then address as necessary potential M/S and BH network deficiencies and report on such efforts to the Commissioner. 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 greater of total OON claims in certain service categories (unless use of a different percentage rate is specifically allowed by the Commissioner), including those categories referenced in Paragraphs 48, 49, 51 and 52, and ;

    B. A process to identify and document on an annual basis rationale as to why THP does not contract with those OON providers identified in subparagraph (A) above who are providing medically necessary services to THP's beneficiaries;

61. 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.

62. 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.

63. Further, THP agrees to provide quarterly updates to the Commissioner for the remainder of the year on its progress on the recommendations in the Report.

64. On or before October 31, 2022, THP 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 THP's plan to address potential network deficiencies identified in subparagraph 60 (A) above.

Appendix A

Information Data Requests

Tufts Insurance Company and Tufts Associated Health Maintenance Organization's

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	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. The Period that applies to this request is January 1, 2019 through August 31, 2019.
2	October 11, 2019	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: 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) The Period that applies to this request is January 1, 2019 through December 31, 2020.

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
2.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
2.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
2.3	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
3	October 11, 2019	For each of the networks (and network tiers, if applicable) listed under request #2 (2019 networks only), a. Provide an electronic copy (Excel or Word format) of the corresponding provider directories* as of the date of the current date in which this request is processed by the Company. If the network ID is not clearly listed in the provider directory file, please provide a key to identify which file is associated with each network. b. Also, please provide an Excel document listing the online web address for access to the 2019 provider directories for each of the identified networks. *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. The Period that applies to this request is September 2019, specifically, the date that the carrier processes this request.
3.1	February 5, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4	October 28, 2019	For each of the networks listed under request #2, provide a separate *Excel* document* listing of all providers including the following data fields: a. Provider Name

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		b. Provider NPI c. Regarding all type 2 NPIs (health organizations such as physician groups, hospitals, nursing homes, clinics, etc.), please include the type 1 NPIs and names (individual health providers such as physicians, licensed clinical social workers, etc.) for the individuals associated with the health organization. d. Provider Address including Zip Code (actual location where services are provided to members)** e. Provider County f. Provider Telephone Number g. Type of Provider as defined under Rhode Island Regulation 230-RICR-20-30-9.3 (23) h. Provider Specialty i. Provider Credentials/Licenses j. Handicap/Special Needs Accessibility (Yes or No) k. Age range of patients treated l. Date provider joined the network (contract date) m. Termination Date, if applicable n. Current Network Status (In-Network or Out-Of-Network) o. Network Tier, If applicable p. Is the professional provider as defined under Rhode Island Regulation 230-RICR-20-30-9.3 (22) accepting new patients? (Yes or No). If no, please provide the reasons why the provider is not accepting new patients q. Are there any limitations for access to care besides the non-acceptance of new patients with the professional provider? (Yes or No). If yes, please state the limitations and explain the reasons why such limitations are in place. r. Hospital admitting privileges (if applicable) or affiliation with in-network facilities s. Date of last filed claim for the provider *Please label the Excel file with the corresponding network name. **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. The Period that applies to this request is January 1, 2019 through August 31, 2019.
4 – A.1	February 19, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that

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.
4 – A.2	February 19, 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 – A.3	February 19, 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 – A.4	February 19, 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 – A.5	February 19, 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 – A.6	February 19, 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	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: 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 The Period that applies to this request is January 1, 2019 through August 31, 2019.
6	October 11, 2019	Please provide the following information. a. The policies and procedures used for updating the provider directory.

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		b. Information provided to providers, including contact number and/or website to update provider contact information or status in the plan network. c. Internal timeline to complete provider directory update requests. d. Process for updating beneficiaries' access to updated provider directory information. e. The procedures for making provider directories available to beneficiaries, providers and the public. This information should include the formats available (print or electronic) and measures taken to accommodate individuals with limited English proficiency and/or disabilities. f. Process and method to inform and assist beneficiaries on how to choose and/or utilize a network plan, select or change a provider, access an updated provider directory in each network plan, and inform the members on the use of tiered networks within a network plan to include changes in beneficiaries' financial liability. Also, provide the dedicated line and telephone number that beneficiaries must call to request assistance with finding care and an available provider. 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.
6.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
6.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
6.3	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
6.4	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
7	October 11, 2019	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. 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.
7.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
7.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
7.3	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
7.4	February 5, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
8	October 11, 2019	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. 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 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that

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.
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: 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 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
10.2	February 5, 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.

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
10.3	February 5, 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	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. 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. Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
11.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12	October 11, 2019	Provide the policies and procedures regarding the ongoing process in place to monitor and assure that the Company's provider network for each of its network plans (and network tiers, if applicable) are *sufficient* **in scope** *and* **in volume** to assure the network will: 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

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		and persons with limited English proficiency, are accessible in a timely manner without unreasonable delay. 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. Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
12.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
13	October 11, 2019	Answer separately for each network (and network tier, if applicable): a. 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. b. 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. 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. d. In reference to all new networks that will be introduced during 2020, please provide a response to inquiries a. and b. above. The Period that applies to this request is January 1, 2019 through August 31, 2019 and calendar year 2020.
13.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that

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.
14	October 11, 2019	Please provide the policies, procedures and protocols for evaluating the adequacy of the Company's network of providers. 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. Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
14.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
14.2	February 5, 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.
15	October 11, 2019	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). 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. Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
15.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
15.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that

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.
15.3	February 5, 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.
15.4	February 5, 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	October 11, 2019	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: 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. 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.

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.
16.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
17	October 28, 2019	For each network separately (and network tier, if applicable), please provide an *Excel* 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: 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

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		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. The Period that applies to this request is September 1, 2017 through August 31, 2019.
17 and 18 – B.1	February 12, 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 and 18 – B.2	February 12, 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 and 18 – B.3	February 12, 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.
17.1 and 18.1	October 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.
18	October 28, 2019	For each network separately, as applicable, please provide an *Excel* 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: a. Policy number b. Type of policy (individual, small group or large group and definition of each) c. Claim number d. Product/plan name e. Network ID f. Network tier, if applicable g. Date of service h. Date received i. Claim amount j. Allowable amount k. Provider Name l. NPI m. Actual provider address where services were provided

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		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 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. The Period that applies to this request is September 1, 2017 through August 31, 2019.
19	October 11, 2019	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. 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.
20	October 28, 2019	For each network (and network tier, if applicable) separately, please provide an *Excel* listing 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: a. Product/Plan name b. Reason for request

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		c. Outcome (approved or denied) d. Percent of coverage (e.g., 100%, 50%, 0%, etc.) e. Service or procedural code requested f. Specialty of Provider requested g. NPI h. Provider address including zip code i. Provider county Please provide a data dictionary or legend that defines the Company's column headings and acronyms that may be used in the requested data. The Period that applies to this request is January 1, 2019 through August 31, 2019.
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 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.
20.4	February 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.
20.5	February 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.
20.6	February 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.
20.7	February 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.

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
21	October 11, 2019	Please provide the policies and procedures demonstrating that network plan beneficiaries have access to a provider in the event that the plan fails to maintain sufficient provider contracts, or a network provider is not available to provide covered services to beneficiaries in a timely manner. 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. 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.
21.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
22	October 11, 2019	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. 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. Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
22.1	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
22.2	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
22.3	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
22.4	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
22.5	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
22.6	December 4, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
23	October 28, 2019	For each network separately, as applicable, please provide an *Excel* listing of all professional provider credentialing or re-credentialing activities during the Period, which should include the following data fields: 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 The Period that applies to this request is January 1, 2019 through August 31, 2019.
24	October 11, 2019	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. 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

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		change during 2020, please provide a detailed summary of such changes.
25	February 5, 2020	The examiners were notified that the Company delegated the website provider directory maintenance to Health Sparq. Please provide the following documents and/or additional information: 1. Copy of the delegation agreement entered into between the Company and Health Sparq. 2. Please explain how the Company ensures through supervision and monitoring controls that Health Sparq is performing the delegated function in accordance with the agreement for the Company's provider directory. 3. A listing of all provider directory related reports provided by Health Sparq to the Company that allows Tufts Health Plan 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 Health Sparq, please state so. 4. A listing of all provider directory quality review reports provided by Health Sparq to the Company during the exam Period. Please explain how the Company used these reports to improve the quality of services provided by Health Sparq. Please provide an example of each report. If the Company did not require any reports from Health Sparq, please state so. 5. A listing of all provider directory quality review reports prepared by Tufts Health Plan regarding transactions processed by Health Sparq during the exam Period. Please explain how the Company used these reports to improve the quality of services provided by Health Sparq. Please provide an example of each report. If the Company did not prepare such reports, please state so. 6. Please provide a list of all vendors the Company may have contracted with to perform any delegated function regarding the areas under review (provider directory, network adequacy and provider credentialing) during the exam period. Please provide a summary explaining the functions performed by each vendor.
25.1	February 5, 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.

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
25.2	February 5, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
25.3	February 5, 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 Request	November 6, 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.
Email Request	August 25, 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 Request	September 2, 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 Request	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.
Email Request	September 25, 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.

Cigna (Appendix A continued)

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 – As discussed with TAHMO, this request is not applicable to Cigna	October 11, 2019	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. The Period that applies to this request is January 1, 2019 through August 31, 2019.
1.1	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
2 – As discussed with TAHMO, this request is not applicable to Cigna	October 11, 2019	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: i. Network Name j. Network ID k. Network Size (based on number of beneficiaries served) l. Indicate the network tiers, if applicable m. Market Served (individual, large group, small group) n. Products Available (as applicable, PPO, EPO, POS, HMO, etc.) o. Servicing Area (as applicable, e.g., all of RI, by county, etc.) p. Will Network be available in 2020? (Y /N) The Period that applies to this request is January 1, 2019 through December 31, 2020.

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
3	October 11, 2019	For each of the networks (and network tiers, if applicable) listed under request #2 (2019 networks only), b. 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. c. Also, please provide an Excel document listing the online web address for access to the 2019 provider directories for each of the identified networks. *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. The Period that applies to this request is September 2019, specifically, the date that the carrier processes this request.
4	October 28, 2019	For each of the networks listed under request #2, provide a separate *Excel* document* listing of all providers including the following data fields: t. Provider Name u. Provider NPI v. 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. w. Provider Address including Zip Code (actual location where services are provided to members)** x. Provider County y. Provider Telephone Number z. Type of Provider as defined under Rhode Island Regulation 230-RICR-20-30-9.3 (23) aa. Provider Specialty bb. Provider Credentials/Licenses cc. Handicap/Special Needs Accessibility (Yes or No) dd. Age range of patients treated ee. Date provider joined the network (contract date) ff. Termination Date, if applicable

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		gg. Current Network Status (In-Network or Out-Of-Network) hh. Network Tier, If applicable ii. 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 jj. 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. kk. Hospital admitting privileges (if applicable) or affiliation with in-network facilities ll. Date of last filed claim for the provider *Please label the Excel file with the corresponding network name. **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. The Period that applies to this request is January 1, 2019 through August 31, 2019.
4 – A.7 (A.1 – A.6 apply to TAHMO)	February 19, 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 – A.8	February 19, 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 – A.9	February 19, 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 – A.10	February 19, 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 – A.11	February 19, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that

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.
4 - A.12	February 19, 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 – A.13	February 19, 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 – As discussed with TAHMO, this request is not applicable to Cigna	October 11, 2019	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: a. Provider Directory, including any staff available to assist members in finding care and those staff dedicated to provider directory updates g. Network Management, performance and adequacy monitoring h. Internal Audit i. Complaints and Grievances j. Professional Provider Credentialing/Re-Credentialing or Certifications k. Compliance regarding Rhode Island requirements The Period that applies to this request is January 1, 2019 through August 31, 2019.
6	October 11, 2019	Please provide the following information. g. The policies and procedures used for updating the provider directory. h. Information provided to providers, including contact number and/or website to update provider contact information or status in the plan network. i. Internal timeline to complete provider directory update requests. j. Process for updating beneficiaries' access to updated provider directory information. k. 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. l. Process and method to inform and assist beneficiaries on how to choose and/or utilize a network plan, select or change a provider,

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		access an updated provider directory in each network plan, and inform the members on the use of tiered networks within a network plan to include changes in beneficiaries' financial liability. Also, provide the dedicated line and telephone number that beneficiaries must call to request assistance with finding care and an available provider. 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.
7	October 11, 2019	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. 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.
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. 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	February 20, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
9 – As discussed with TAHMO, this request is not applicable to Cigna	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: k. Policy number l. Network ID m. Source of complaint/grievance review request (beneficiary, provider, OHIC, claimant's attorney, etc.) n. Type of coverage (medical, mental health, etc.) o. Type of complaint/grievance (adequacy of network, provider directory error, etc.) p. Company identification number/code for the complaint/grievance q. Reason for complaint/grievance r. Date request received s. Date resolved t. Outcome The Period that applies to this request is January 1, 2019 through August 31, 2019.
		Network Adequacy Requests
11	October 11, 2019	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. 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

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		the processes noted above. If such work flow charts do not exist, please create them. Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
11.1	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12	October 11, 2019	Provide the policies and procedures regarding the ongoing process in place to monitor and assure that the Company's provider network for each of its network plans (and network tiers, if applicable) are *sufficient* **in scope** *and* **in volume** to assure the network will: 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. 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. Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
12.1	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.
13	October 11, 2019	Answer separately for each network (and network tier, if applicable): e. 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. f. 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,

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		or quality of services, etc.? Describe the process and provide supporting documentation. g. 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. h. In reference to all new networks that will be introduced during 2020, please provide a response to inquiries a. and b. above. The Period that applies to this request is January 1, 2019 through August 31, 2019 and calendar year 2020.
13.1	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.
14	October 11, 2019	Please provide the policies, procedures and protocols for evaluating the adequacy of the Company's network of providers. 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. Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
14.1	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.
15	October 11, 2019	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). 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

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		the processes noted above. If such work flow charts do not exist, please create them. Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
15.1	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.
15.2	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.
16	October 11, 2019	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: i. GeoAccess or similar tools and results applicable to the Period; j. Ratios of providers to covered persons; k. Waiting time for appointments; l. Other geographic accessibility testing, as measured by the reasonable proximity of participating providers to the business or personal residence of covered persons; m. Hours of operation; n. Availability of emergency care facilities and procedures; o. Volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. p. Out-of-network claims volume and the reasons for such claims. 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

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		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. Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.
16.1	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.
17 – Claims data included in TAHMO response	October 28, 2019	For each network separately (and network tier, if applicable), please provide an *Excel* 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: aa. Policy number bb. Type of policy (individual, small group or large group and definition of each) cc. Claim number dd. Product/plan name ee. Network ID ff. Network tier, if applicable gg. Date of service hh. Date received ii. Claim amount jj. Allowable amount kk. Paid amount ll. Cost sharing amount applied (dollar amount beneficiary was responsible for) mm. Provider Name nn. National Provider Identifier (NPI) oo. Network status (in or out-of-network) pp. Actual provider address where the services were provided qq. Type of service (emergency, inpatient, outpatient, partial hospitalization, residential treatment facility, office visit, etc.) rr. Primary diagnosis code ss. Secondary diagnosis code tt. Tertiary diagnosis code uu. All other available diagnosis codes in the system associated with the line item

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		vv. Procedure/Revenue code ww. Remark Code xx. Indicator for manual or auto adjudication yy. Date approved zz. Date paid 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. The Period that applies to this request is September 1, 2017 through August 31, 2019.
18 – Claims data included in TAHMO response	October 28, 2019	For each network separately, as applicable, please provide an *Excel* 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: z. Policy number aa. Type of policy (individual, small group or large group and definition of each) bb. Claim number cc. Product/plan name dd. Network ID ee. Network tier, if applicable ff. Date of service gg. Date received hh. Claim amount ii. Allowable amount jj. Provider Name kk. NPI ll. Actual provider address where services were provided mm. Network status (in or out-of-network) nn. Type of service (emergency, inpatient, outpatient, partial hospitalization, residential treatment facility, office visit, etc.) oo. Primary diagnosis code pp. Secondary diagnosis code qq. Tertiary diagnosis code rr. All other available diagnosis codes in the system associated with the line item ss. Procedure/Revenue code tt. Indicator for manual or auto adjudication

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		uu. Denial code vv. Denial reason ww. Date denied xx. Date explanation of benefits mailed 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. The Period that applies to this request is September 1, 2017 through August 31, 2019.
19	October 11, 2019	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. 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.
20	October 28, 2019	For each network (and network tier, if applicable) separately, please provide an *Excel* listing 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: j. Product/Plan name k. Reason for request l. Outcome (approved or denied) m. Percent of coverage (e.g., 100%, 50%, 0%, etc.) n. Service or procedural code requested o. Specialty of Provider requested p. NPI q. Provider address including zip code r. Provider county

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		Please provide a data dictionary or legend that defines the Company's column headings and acronyms that may be used in the requested data. The Period that applies to this request is January 1, 2019 through August 31, 2019.
20.1	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.
21	October 11, 2019	Please provide the policies and procedures demonstrating that network plan beneficiaries have access to a provider in the event that the plan fails to maintain sufficient provider contracts, or a network provider is not available to provide covered services to beneficiaries in a timely manner. 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. 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.
21.1	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.
22		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. 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.

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.
23	October 28, 2019	For each network separately, as applicable, please provide an *Excel* listing of all professional provider credentialing or re-credentialing activities during the Period, which should include the following data fields: j. Provider Name k. Reason for request (credentialing or re-credentialing) l. NPI m. Provider address including zip code n. Provider county o. Receipt date of completed application or request p. Decision (approved or denied) q. Date of decision r. Date decision communicated to provider The Period that applies to this request is January 1, 2019 through August 31, 2019.
24	October 11, 2019	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. 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.
Email Request	October 18, 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.

Appendix B

Claims Data Analysis

I. Introduction:

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

II. Methodology to Analyze Claims Identified by Procedure Code:

A. Initial Procedure Code Filters.

Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively "THP") submitted two spreadsheets for the Exam Period, segmented on these excel spreadsheets by paid or denied. These spreadsheets were consolidated into a unified data model in Microsoft Power BI, which collated 729,313 claims. 331,965 procedure code claims remained after the Examiners excluded the following coding classifications, which was done to isolate out-of-network claims by volume and to identify potential network inadequacies:

- CPT codes 00100 – 01999; 99100 – 99140: Anesthesia
- CPT codes 10021 – 69990: Surgery:
- CPT codes 70010– 79999: Radiology:
- CPT codes 80047 – 89398: Pathology and Laboratory
- A-codes: Transportation, Medical & Surgical Supplies, Miscellaneous & Experimental
- B-codes: Enteral and Parenteral Therapy
- D-codes: Dental Procedures
- E-codes: Durable Medical Equipment

- J-codes: Drugs Administered Other Than Oral Method, Chemotherapy Drugs
- K-codes: Temporary Codes for Durable Medical Equipment Regional Carriers
- L-codes: Orthotic/Prosthetic Procedures
- M-codes: Medical Services
- P-codes: Pathology and Laboratory
- R-codes: Diagnostic Radiology Services
- V-codes: Vision/Hearing Services

The Examiners then narrowed the claims data to only those facility and professional procedure codes where greater than 5% of the coded claims were out-of-network and where there were at least 25 claims for each code that was out out-of-network. After these two filters were applied, the remaining 221,798 claims were analyzed as noted below.

B. Procedure Codes Analyzed:

In THP Procedure Code Table 1 No Dx Tab 1, the Examiners removed procedure codes that had a similar service category to those service category codes already excluded via the process noted in Section II A above. THP Procedure Code Table 1 No DX, Tab 2 identifies the remaining 190,278 professional procedure claims, which were then analyzed by the Examiners to assess network inadequacies, as presented within the market conduct examination main report ("MCE"). The Examiners then reviewed the claims analyzed in Procedure Code Table 1, Tab 2 to identify related diagnoses. Procedure Code Table 2 With Dx, Tab 2 shows diagnoses with at least 6 OON claims representing 74,336 claims. These claims were further analyzed as shown on THP Procedure Code Table 2 With Dx, Tabs 2-4 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.

THP submitted two Excel spreadsheets for the Exam Period referenced above, segmented by paid or denied. These were consolidated into a unified data model in Microsoft Power BI, which resulted in 729,313 claims. The Examiners selected only the claims with a valid Revenue Code which resulted in 239,619 claims. The Examiners then applied an additional filter to include, by revenue code, only those Revenue Code claims where there were greater than 10 claims for each code that was out-of-network, which resulted in 231,210 claims.

B. Revenue Codes Analyzed.

The Examiners analyzed the 231,210 claims, as shown on THP Revenue Code Table 1 No Dx, Tab 1, and removed the claims with revenue codes similar to the service categories excluded in Section II A above. Revenue Code Table 1 No Dx, Tab 3 presents the resulting 32,981 revenue coded claims, which were then analyzed by the Examiners to identify network inadequacies, as presented in the MCE report. The Examiners further analyzed the claims in THP Revenue Code Table 1 With Dx identifying related diagnoses and applying a filter to require at least five or more OON claims as seen on THP Revenue Code Table 2 With Dx, Tab 2. These Table 2 claims totaling 5,128 were then used to provide diagnostic detail on network inadequacies as identified by the Examiners in the MCE report.

Appendix C

Procedure Code Data

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

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.

Wherefore, it is hereby ORDERED:

A. The Commissioner hereby adopts the Examination Report and Recommendations.

B. THP shall report to the Commissioner on January 31, 2023, regarding the implementation of all Recommendations in this report.

C. THP shall provide a compliance audit and other such information as reasonably requested by the Commissioner.

D. In lieu of a penalty, THP shall make a financial contribution to the Rhode Island Foundation (RIF) in the total amount of $100,000.00. The contribution dollars shall be used to support the Rhode Island perinatal workforce, including but not limited, to the doula workforce community in the areas of workforce development and training. It is the Commissioner's expectation that the $100,000.00 financial contribution in lieu of penalty shall be sent to RIF no later than 60 days after the issuance of this Order. This doula contribution payment shall be separate from, and in addition to THP's cost of implementing this Report's Recommendations and Orders.

E. Within 30 days of the issuance of this Order, and in accordance with R.I.G.L 27-13.1-5, THP shall file with the Commissioner affidavits executed by each of its Directors stating under oath that they have received a copy of the adopted Report and related Orders.

F. The Commissioner shall retain jurisdiction over this matter to take such further actions, and issue any supplemental orders deemed necessary and appropriate

to address the Report's findings, and to implement the Report's Recommendations, and Orders. Such further actions may include but not be limited to validation studies conducted by the OHIC to verify compliance with these Orders. THP shall pay the costs of any such further actions or supplemental orders.

Dated at Cranston, Rhode Island this 12th day of April, 2022.

Patrick Tigue, 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.

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

Consent of Tufts Insurance Company and Tufts Associated Health Maintenance Organization, Inc. (collectively "THP")

I. THP understands and agrees that this Order constitutes valid obligations of THP, legally enforceable by the Commissioner.

II. THP waives its right to judicial review with respect to the above-referenced matter; provided, however, THP shall have a right to a hearing on any charge or allegation brought by OHIC that THP failed to comply with, or violated any of its obligations under this Order, and THP shall have the right to appeal any adverse determination resulting from such charge or allegation.

III. THP 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: 4/18/2022

Title: Chief Legal Officer

TUFTS Health Plan

April 1, 2022

Patrick M. Tigue
Health Insurance Commissioner
Office of the Health Insurance Commissioner
State of Rhode Island
1511 Pontiac Avenue, Building 69-1
Cranston, RI 02920

RE: Examination of Health Insurance Carrier Compliance with Network Adequacy and Provider Directory Laws and Regulations (OHIC-2019-9)

Dear Commissioner Tigue:

Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively, "Tufts Health Plan") respectfully submit this written response to the Final Report ("Report") issued by the Office of the Health Insurance Commissioner ("OHIC") pursuant to the above referenced Examination. The Report primarily covers the 2019 time period. Tufts Health Plan acknowledges that it has made and will continue to make improvement in its processes since 2019 and will collaborate with the OHIC to implement the recommendations of the Report and to file a Plan of Correction in connection therewith. At the same time, however, Tufts Health Plan does not concur with several of the factual and legal findings in the Report and denies any inference of wrongdoing in connection with the Examination, particularly as it relates to the processes used to monitor and assess network adequacy, and to oversee such activities of its delegates.

Unlike other dominant carriers in the Rhode Island commercial market, Tufts Health Plan is a regional health plan with a service area that includes Rhode Island, Massachusetts, New Hampshire and bordering areas (parts of Vermont, Connecticut, and Maine). Our ever-expanding network encompasses approximately 117,500 providers, 560 hospitals and 6,895 allied health facilities, including every acute care hospital/facility in our primary service area (outside of VA hospitals) and many of the leading and preeminent hospitals in America and around the world. In order to offer its Rhode Island plans nationwide coverage, Tufts Health Plan contracts with a national carrier to utilize its provider network for services our members receive outside of our service area. Yet, despite the robust provider network we maintain and that this partnership provides (neither of which is cited by the Examiners as inadequate), member choice to seek care with any provider is of critical importance to Rhode Island residents and employers. Half of Tufts Health Plan's fully-insured Rhode Island membership is enrolled in Preferred Provider Organization (PPO) plans – plans for which a greater premium is paid to have access to covered services with any provider, free of network restrictions. As expected, the overwhelming majority (more than 75%) of out-of-network utilization cited by the Examiners in this Report are from members on PPO plans, primarily for services obtained outside of Tufts Health Plan's service area.

TUFTS Health Plan

It has been Tufts Health Plan's consistent practice to regularly monitor and evaluate the quality of services delivered to its members and assess whether there are network inadequacies that would have the potential to adversely impact the delivery of covered services as required by Rhode Island law. In the absence of any Rhode Island specific instruction clarifying such Rhode Island requirements, Tufts Health Plan believes that its quality assurance program was reasonably developed and maintained, consistent with federal guidelines, industry practice, and other related quality assurance standards.

This quality assurance program includes provisions related to oversight of the national carrier to whom we delegate network access for services received by Rhode Island plan members outside of our service area. Tufts Health Plan's delegate complies with the credentialing and re-credentialing, provider directory, and network adequacy monitoring requirements for its provider network outside of Rhode Island as required by the laws of those other states and does not interpret Rhode Island's corresponding laws to be applicable to residents receiving care outside of the state or to extend Rhode Island's jurisdiction to regulate out-of-state providers who are not performing services within Rhode Island and who are already appropriately regulated by the laws of the states where they do perform their services. To the extent the Examiners have a different interpretation regarding the reach of OHIC's jurisdiction, Tufts Health Plan requests that such expectations be clearly communicated and administered so that all carriers and, if applicable, delegates are held to equal standards with regard to their provider networks outside of Rhode Island.

Tufts Health Plan continues to support efforts to expand access to care with a strong focus on advancing health equity in the communities we serve. Our health equity efforts are focused on collective strategies that maximize our internal resources and leverage public and private collaborations. Underscoring this organizational commitment is the initiation of process toward health equity accreditation by the National Committee for Quality Assurance. Our work to address social determinants of health includes providing services that support prevention and wellness, affordability, and the removal of obstacles to health care accessibility. For example, to address food insecurity and other dietary support needs, we are partnering with Meals on Wheels and Women and Infants Hospital to offer nutritional support to eligible Rhode Island members during pregnancy and postpartum. We have also introduced provider contractual agreements that target reduction of health disparities through increased quality measures and different payment models to incent better care and outcomes for people of color. We are developing clinical programs to target health equity and emergency department divergence through the use of population health analytics. These initiatives are informed through learning obtained as an active member (through our parent organization) of the Health Equity Compact, a Massachusetts coalition of health care leaders with lived experience, seeking to dismantle systemic barriers to equitable health outcomes and transforming care delivery and influencing health policy. Since the pandemic, we have also expanded access to telehealth services, with a goal toward access, equity and affordability – resulting in a sustained increase in utilization for behavioral health services.

TUFTS Health Plan

Tufts Health Plan remains committed to delivering high quality health care coverage and services to our Rhode Island members and to working with OHIC and key stakeholders across the State to improve access to care, including critical behavioral health services and services to address the public health crisis. We trust that these efforts to date, including our investment to the Rhode Island Foundation, address the concerns and recommendations of the Examiners.

Sincerely,

Susan Kee

Susan Kee
Vice President, Deputy General Counsel

cc: Beth Roberts, President of Commercial Business
James Delisle, Rhode Island Commercial Market Lead
Kristin Lewis, Chief Government Affairs Officer