

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 UnitedHealthcare Insurance Company and UnitedHealthcare of
New England, 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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February 3, 2022

Honorable Patrick Tighe
Health Insurance Commissioner
State of Rhode Island

Dear Commissioner Tighe:

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

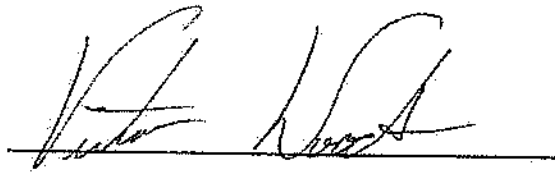
The examination was conducted by Emily Maranjian, OHIC General Counsel, Victor Woods, OHIC Health Economic Specialist, Linda Johnson, LLC, James Lucht Consulting, and Risk & Regulatory Consulting, LLC.



Emily Maranjian, Esq.

Office of the Health Insurance Commissioner

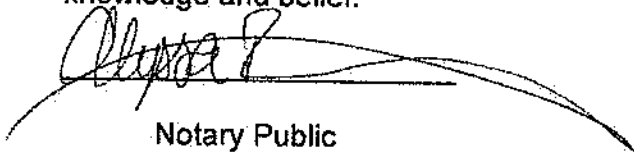
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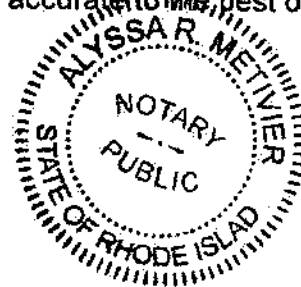
Victor Woods, Health Economic Specialist

Office of the Health Insurance Commissioner

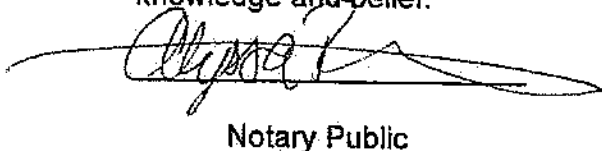
On this 3 day of February, 2022, before me, the undersigned notary public,
personally appeared Emily Maranjian, personally known to the notary to be the person
who signed the Examination Report in my presence, and who swore or affirmed to the
notary that the contents of the document are truthful and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



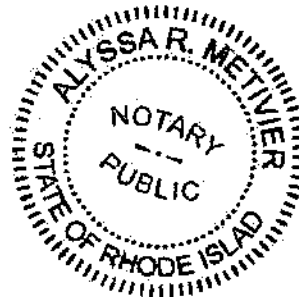
Notary Public



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



Notary Public



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1. Introduction

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

The purpose of the Examination was to review the Carriers' compliance with state and federal laws and regulations relating to the adequacy of 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.

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This examination report addresses findings of non-compliance and/or non-compliant practices of United and its delegate Optum Behavioral Health (BH Delegate). 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 Period¹. Any failure to identify a non-compliant practice shall not be considered approval or acceptance of said practice by OHIC and does not prohibit or limit in any way future enforcement of laws and regulations relating to Network Adequacy and Provider Directories.

2. Applicable statutes and regulations

A. Complaint and Grievance Process. Pursuant to R.I.G.L. § 27-18.8-3 (b) (4) and 230-RICR-20-30-9.6 (A) (1–4), carriers are required to maintain a grievance and complaint process that includes a mechanism where a beneficiary², a beneficiary's authorized representative or a provider can seek timely resolution 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

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 terms "beneficiary" and "member" interchangeably.

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include: resolution of grievances or complaints (hereinafter, complaints) within 30 days; annual communication explaining the Complaint Process to beneficiaries and providers; and an accurate monitoring and reporting process. Failure to provide a compliant Complaint Process compromises the complainant's right to a timely and reasonable resolution to their complaint.

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

- B. Carrier Oversight. Carriers are obligated, pursuant to R.I.G.L. § 27-18.8-3 (b), 230-RICR-20-30-9.5 (B) and 230-RICR-20-30-9.6 (E), to develop, implement and maintain a quality assurance program that provides oversight of all their activities, whether delegated or not. This required ongoing oversight includes processes to regularly evaluate carrier activities (e.g., maintaining an accurate Provider Directory, maintaining an adequate

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

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professional and facility provider network, compliant complaint management, and ensuring behavioral health (BH) parity) and determine whether these carrier activities are being performed in a manner that maintains availability, accessibility, continuity and quality of services for its beneficiaries and ensures that such activities do not adversely affect the delivery of covered services. Failure to provide effective oversight of such activities negatively impacts a beneficiary's ability to access and obtain necessary covered services.

- C. Behavioral Health Parity. Carriers are required to provide coverage for BH disorders⁴ at parity with medical-surgical (M/S) services according to 42 U.S.C. § 300gg-26, 45 CFR 146.136, 45 C.F.R. § 146.136 (c) (4) (ii) (D), R.I.G.L. § 27-38.2-1 (a) (c) & (d) and 230-RICR-20-30-9.6 (F). These rules specify that carriers shall not impose non-quantitative treatment limitations for the treatment of BH disorders unless the processes, strategies,

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 (ICD) published by the World Health Organization; provided, that tobacco and caffeine are excluded from the definition of 'substance' for the purposes of this chapter."

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evidentiary standards or other factors used in applying non-quantitative treatment limitations⁵, as written and in operation, are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used in applying limitations for M/S benefits.

Furthermore, carriers are also prohibited from imposing additional 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.

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

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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

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organ or part. Furthermore, 230-RICR-20-30-9.7 (A) (2) requires that a carrier provide its beneficiaries immediate access to "emergency services" twenty-four hours a day seven days per week. Pursuant to R.I.G.L. § 27-18.9-2 (36) and 230-RICR-20-30-14.3 (39) "urgent health care services" are defined as those resources necessary to treat a symptomatic medical, mental health, substance use, or other health care condition that a prudent layperson, acting reasonably, would believe necessitates treatment within a twenty-four hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. Given these statutory and regulatory definitions, an adequate network must make emergency services available to its beneficiaries immediately and urgent services available to its beneficiaries within twenty-four hours. Failure to provide sufficient in-network (INN) provider access to emergency and urgent services would adversely affect the safety and welfare of beneficiaries and increase beneficiaries' financial obligations for these out-of-network (OON) emergency and urgent services.

- F. Quarterly Network Monitoring. A carrier is required to have ongoing processes that monitor the adequacy of its networks for its population of beneficiaries on at least a quarterly basis, as set forth in R.I.G.L. § 27-18.8-3 (c) (2) and 230-RICR-20-30-9.7 (B), the latter further requiring that such

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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 ensures 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

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accessing care and additional financial burdens if a beneficiary unknowingly obtains health care services from an OON provider.

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

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

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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

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power to do so." Failure to do so impedes the Examiners ability to effectively conduct Market Conduct Examinations.

3. Examination methodology and process

- A. In conducting the Examination, the Examiners observed those guidelines and procedures set forth in the National Association of Insurance Commissioners Market Regulation Handbook ("Handbook") and other appropriate guidelines and procedures that the Commissioner deemed appropriate.
- 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 a particular focus on:
 - a. The accuracy of the carrier's Provider Directories;
 - b. Carrier maintenance of its Provider Directories for all network offerings;
 - c. Carrier policies and procedures for updating and managing its Provider Directories;
 - d. Carrier's internal and external audit and compliance policies and processes;

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- 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 complaint logs.
- ii. Compliance with state Network Adequacy laws and regulations, with a particular focus on:
 - a. The carrier's policies, procedures, criteria, and selection standards regarding the admission of providers to the carrier's provider network;
 - b. The carrier's provider credentialing/re-credentialing policies and procedures for each type of professional provider within the plan network (e.g., medical, surgical, and behavioral health);
 - c. The carrier's provider credentialing/re-credentialing activities;
 - d. Carrier policies, procedures, and processes that audit, monitor and ensure that its provider network for each of its network plans (and network tiers, if applicable) are sufficient in scope and in volume;

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

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- i. Professional and Facility Claims using Procedure Codes (Procedure 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 United complaints and United Complaint Processes for the purpose of assessing the adequacy of United's network and the accuracy of its Provider Directories the Examiners discovered some compliance failures in the Complaint Processes. These failures compromised the value of this source of examination data, negatively impacting the Examiners' ability to assess Network Adequacy and Provider Directory accuracy.

Complaint Findings and Conclusions

5. The Examiners reviewed United's Complaint Processes and Complaint Log⁶, which were submitted in response to IDR 10, in order to determine if there were any Provider Directory and Network Adequacy issues that may have been expressed in these complaints and to identify United's responses to Provider

⁶ References to United Complaint Log in this report refer to the documents submitted by United in response to IDR 10.1 entitled "RI MCE Complaint Log-Regulatory Complaints" and "RI UHIC UHCNE ETS Complaint Logs".

Directory and Network Adequacy issues. This review led the Examiners to assess whether United's Complaint Processes were compliant with Rhode Island law. The Examiners' findings and conclusions are as presented in Paras. 6-18 herein.

6. The Examiners initial review of United's response to IDR 10.0 revealed that the Compliant Log was incomplete. Thus, the Examiners requested additional information via IDR 10.1. In response to IDR 10.1 United submitted a second Complaint Log which included additional complaint log entries that were not included in its IDR 10.0 response. United provided the following statement along with this updated Complaint Log: "We have met with both UnitedHealthcare and Optum Behavioral Health's complaint and grievance reporting team and have requested a verification re-pull of data. Both groups have confirmed that the data provided is accurate and complete for the period under review and based on RI Regulation 20-30-14 (14.3.11), with one exception. We inadvertently omitted from our initial submission Optum Behavioral Health regulatory complaints. Our apologies for this oversight. Please see folder 10.1 for the revised list. New cases highlighted for ease of reference." Accordingly, three additional complaints were added by United to its Complaint Log that was submitted in response to IDR 10.1.

7. The Examiners reviewed the updated Complaint Log submitted in IDRs 10.1 and compared the 15 complaint files listed on this updated United Complaint Log in addition to the one United BH Delegate complaint submitted on this delegate's Complaint Log in IDR 10.0 to the internal complaint logs maintained by OHIC. Examiners noted that all complaints received by OHIC are forwarded to the appropriate Carriers for resolution. Additionally, United and its BH Delegate are required to include all complaints received in its complaint logs whether received from OHIC or other sources. Thus, United and its BH Delegate are required to include all complaints forwarded to it by OHIC in its complaint logs. OHIC forwarded 13 complaints to United for processing during the Exam Period, 9 of which related to fully insured commercial insurance products. The following two forwarded complaints, as identified by the following OHIC tracking numbers, were not contained in United's Complaint Log (see Appendix E, OHIC Complaint Identifications Document):
- A. 54818 Prompt Pay; and
 - B. 55021 Credentialing Delay.
8. The Examiners identified the source of the 16 complaints submitted by United and its BH Delegate in its response to IDRs 10.0 and 10.1. Of these 16 complaints, ten were received from OHIC, two from United's BH Delegate's Consumer Affairs department, one from United's Media Relations department,

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one from an elected official's office, one from Social Care (it is not clear if this was from an internal United department or external agency), and one from a provider. The Examiners found that complaints are received by United and it's BH Delegate through a variety of entry points. The Examiners further found that United reported receiving a total of four complaints directly (including directly through its BH delegate) from members and/or providers on its Complaint Log (a total of three member complaints and one provider complaint) for the entirety of the eight-month Exam Period. United's low volume of reported complaints received directly, considering Rhode Island law which defines a complaint as a verbal or written expression of dissatisfaction (see Para. 2 (A) above), led the Examiners to observe that United did not substantiate that it accurately captured, processed, logged and reported all complaints directly communicated to United and/or its BH Delegate during the Exam Period.

9. Conclusions of Law. Based on the findings in Paras. 6-8 United and its BH Delegate did not substantiate that it accurately logged and monitored all of its complaints nor did it report all of its complaints to OHIC as required by R.I.G.L. § 27-18.8-6, 230-RICR-20-30-9.6 (A) (4), and 230-RICR-20-30-9.10 (A).
10. In response to IDR 10.4 United's submitted a document titled "CEU_UnitedHealthcare Appeal policy (appeal, complaint, inquiry definition.pdf" which defines a complaint as "Any written or oral communication by an enrollee

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or authorized representative, broker, employer, or network provider regarding dissatisfaction relating to UnitedHealthcare products, benefits, coverage services, operations, policies or network providers." The Examiners find this definition to be materially narrower than the Rhode Island statutory and regulatory definition of a complaint, including narrowing the definition to only encompass complaints registered by network providers and this limited listing of complainants.

11. In response to IDR 10.4, United also submitted its BH Delegate's national policies, submitted as 10.4.d._Mmbr NonClin QOC Complaints_OBH" and "10.4.d._Mmbr NonClin QOC Complaints_OBH". In both these policies, the BH Delegate defined a complaint as "An expression of dissatisfaction, whether oral or written, by an Optum member or member representative that is elevated to the complaint resolution system." This definition only categorizes communications of dissatisfaction as complaints when such communication is elevated by United to the complaint resolution system - this is not compliant with the Rhode Island statutory and regulatory definition of a complaint. Further, United's BH Delegate defined an "inquiry" in these national policies as, "... an issue that is resolved during the initial telephone conversation or is a written or oral request for information or action that does not include an expression of dissatisfaction and, is *not* to be considered a complaint." As written, this

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definition allows an expression of dissatisfaction to be classified as an inquiry and not as a complaint if it is resolved during an initial telephone communication which does not meet the requirements of Rhode Island law. The Examiners therefore concluded that in the absence of a Rhode Island addendum that specifically overrides the national policy's definition and processing of an inquiry, as noted in Para. 12, United is not compliant with the Rhode Island statutory and regulatory definition of a complaint.

12. In response to IDR 10.4 United submitted another response document, a BH Delegate document titled "RI Member Complaint & Grievance Addendum" where United's BH Delegate presented a Rhode Island addendum setting forth a differing definition of complaint, specifically that a complaint or grievance is "...an oral or written expression of dissatisfaction by a beneficiary, authorized representative, or provider. The appeal of an adverse determination is not considered a complaint or grievance." Though this addendum language tracks Rhode Island's statutory and regulatory definition of a complaint, it does not change United's BH Delegate's definition of inquiry presented in its national policy documents noted in Para. 11 and, as such, the Examiners find that this addendum is not sufficient to ensure that United's BH Delegate is defining and processing complaints using a Rhode Island compliant definition of a complaint. In addition, the limited addendum language taken together with the totality of

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United's BH Delegate's IDR 10 responses fails to evidence any procedures or processes explaining how this addendum definition is or conceivably could be operationalized into United's BH Delegate's practices in Rhode Island. The Examiners therefore find that this addendum is insufficient to revise, for use in Rhode Island, United's and its BH Delegate's national definitions of a "complaint" in a manner consistent with the Rhode Island statutory and regulatory definition of a "complaint". Finally, there is no evidence that the addendum document "10.4.d_RI Comp_Grievance Addendum" provided by the BH Delegate was in effect during the Exam Period and the creation date of this limited text addendum is January 22, 2020 which is after the Exam Period.

13. The three policies submitted in response to IDR 10.4 and detailed in Paras. 10-12 indicate that the definitions of "complaint" used by United and/or its BH Delegate to identify complaints limits who can register a complaint in a manner more narrow than the statutory and regulatory definition of complaint. The BH Delegate titles its national policies and its Rhode Island addendum as member complaint policies (see Paras. 11 and 12) and United's definition of complaint (see Para. 10) limits provider complaints to INN providers.
14. Conclusions of Law. As presented in findings noted in Paras. 10-13, United did not define "complaints" in accordance with the definitions set forth in R.I.G.L. § 27-18.8-2 (8) and 230-RICR-20-30-9.3 (A) (9) and instead utilized definitions of

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"complaints" that were significantly narrower in scope, including by allowing complaints to be redefined as inquiries and limiting who can register a complaint. As explained in more detail in Para. 12, the document titled "RI Member Complaint & Grievance Addendum" fails to negate this conclusion of law. Failure to define, categorize, and report all complaints results in underreporting of complaints to OHIC and OHIC's subsequent inability to determine United's compliance with the required processing of complaints as set forth in 230-RICR-20-30-9.6 (A) (1-4). In addition, the Examiners were unable to accurately determine the level of member and provider Network Adequacy and/or Provider Directory concerns due to the underreporting of complaints by United.

15. In response to IDR 9, United submitted its Small Group Certificate of Coverage (COC) titled "COC 18-INS-2018-SG-RI_Rev1," which directs members to call with complaints and then, if desired, to obtain the address from the United representative where they can submit a complaint. This COC also states, "If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it." In response to IDR 10.4 United submitted its BH Delegate's document titled "Member Clinical Quality of Care Complaints," which allows a maximum of 90 calendar days for

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the processing of quality of care complaints. United's response to IDR 10.4 also provided its BH Delegate's document titled "Member Non-Quality of Care Complaints," which includes a resolution timeline of 30 days from a complaint's receipt date. Finally, United submitted its State-specific BH Delegate's document titled "RI Member Complaint and Grievance Addendum," which states that the timeframe for resolving complaints should not exceed 30 calendar days. This Rhode Island specific addendum does not distinguish between clinical and non-clinical complaints nor does it specify whether and/or how it applies to these sub-categories of complaints noted in United's submitted BH national policies. Further, United's submissions failed to evidence how it incorporates and operationalizes the Rhode Island addendum language into its overall complaint process. The Examiners therefore find that this addendum is insufficient to ensure that United and United's BH Delegate's policies and practices around resolution of complaints are completed within the required 30 calendar day timeframe.

16. **Conclusions of Law.** Based on the findings in Para. 15, United's written policies and Certificate of Coverage fail to comply with the 30-calendar day resolution timeframe set forth in R.I.G.L. § 27-18.8-3 (b) (4) and 230-RICR-20-30-9.6 (A) (2) and (3). United presented several documents that included different complaint resolution turnaround times for United and its BH Delegate. Two of

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the complaint policy documents submitted identify turnaround times that exceeded the regulatory timeframe. As explained in more detail in Para. 15 the document titled "RI Member Complaint and Grievance Addendum" fails to negate this conclusion of law.

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

18. Conclusions of Law. Based on the findings in Para. 17 the Examiners concluded that United did not consider beneficiary and provider Network Adequacy and Provider Directory related complaints in its oversight efforts to ensure Network Adequacy and accuracy of its Provider Directory in violation of the 230-RICR-20-30-9.6 (B) (2) and 230-RICR-20-30-9.6 (E). These rules require that United maintain a process that ensures that issues brought to the attention of United regarding its network plans via its Complaint Processes are regularly considered and addressed by United in the context of developing,

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reviewing and evaluating the adequacy of its networks and the accuracy of its Provider Directory.

Complaint Recommendations

19. United shall implement the following recommendations in order to remediate the non-compliant practices found by the Examiners and described in Paras. 6–18, within ninety days from the date the consent order is signed by both parties, United shall implement each of the following Complaint Recommendations set forth in Paras. 20-23 and further implement the Complaint Recommendation outlined in Para 24 by the date specified.
20. United shall establish Rhode Island specific policies and procedures⁷ to identify, manage and process its complaints, establishing the following:
- A. Revision of its definition of “complaint” to comply with R.I.G.L. § 27-18.8-2 (8) and 230-RICR-20-30-9.3 (A) (9), including ensuring the definition of inquiry does not result in classification of some complaints as inquiries;
 - B. The accurate logging, processing and reporting of all complaints shall be defined and processed in accordance with 230-RICR-20-30-9.3 (A) (9) and 230-RICR-20-30-9.6 (A) (1-4). This shall include a procedure to ensure that complaints are accurately categorized as complaints.

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

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- C. Revise all applicable documents and policies to reflect Rhode Island complaint processing timelines; and
 - D. Revise processes to ensure that complaints received from different areas in and outside of United (e.g., Consumer and Provider Service Representatives, Customer and Provider Research staff and Complaint and Grievance staff, RIREACH, OHIC, and other state and federal agencies) are properly categorized and logged as complaints in a central complaint database and accurately reported to OHIC.
21. United shall create and provide training as necessary, to Consumer and Provider Services personnel, as well as Complaint Reporting personnel to align with Para. 20 above. United shall provide such training upon any revision of applicable policies and procedures and then on a periodic basis no less than annually for the next 5 years or for a shorter period of time as determined by the Commissioner.
22. United shall establish a Rhode Island specific audit process to monitor the activity of Consumer and Provider Services personnel, as well as staff that report complaints, to ensure compliance with its revised complaint and grievance policies and procedures. United shall engage in an objective process acceptable to the Commissioner to perform an annual audit of Consumer and Provider Services personnel, as well as staff that report complaints, to assess

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and document compliance or the lack thereof with its revised complaint and grievance policies and procedures as well as with Rhode Island laws and regulations. This audit shall be submitted to OHIC annually, no later than 60 days post-audit completion, for the next five years or a shorter duration as determined by the Commissioner.

23. United shall establish Rhode Island specific processes and procedures regarding reporting and monitoring complaints to ensure the accurate documentation and reporting of all complaints to OHIC.
24. United shall prepare and submit a report to OHIC which shall identify and summarize all complaints received relating to Network Adequacy and Provider Directory issues during June 1, 2022 through December 31, 2022 that will be submitted on January 31, 2023. This report shall further convey how United incorporated complaint information into its periodic monitoring and assessment of its Network Adequacy and Provider Directory accuracy.

Provider Directory Findings and Conclusions

25. The Examiners reviewed United'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 United staff on October 10, 2019 and December 12, 2019 (hereinafter "Interviews"), to evaluate the

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accuracy of United's Provider Directory. The Examiners findings and conclusions are set forth in Paras. 26-36.

26. In response to IDR 6, which requested information about procedures for updating Provider Directories, United produced a document titled "Provider Directory Maintenance Schedule Standard Operating Procedure (SOP)" which stated that "Paper directories are updated: Twice a year (April and September) for E&I [Employer and Individual]." In response to IDR 3 where the Examiners requested an electronic copy of its Provider Directory, United produced a zip file titled "UHC Paper Directory Files" which contained PDF files showing its paper Provider Directories for three of its United networks. Each of these paper Provider Directories were labeled "Fall/Winter 2019 edition" and stated, "The information contained in this document is accurate as of September 2019. The next edition will be published in March 2020." Additionally, the Examiners noted during the Provider Directory interviews that United employees verified this information and indicated that United updated its paper Provider Directories twice annually, once in April as the "Spring/Summer" edition and once in September as the "Fall/Winter" edition. Upon review, United failed to adhere to the Rhode Island requirements to update paper Provider Directories at least monthly.

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27. Conclusions of Law. Based on the findings in Para. 26, United is not in compliance with R.I.G.L. § 27-18.8-3 (c) (4) and 230-RICR-20-30-9.7 (D) (4), as its paper Provider Directories are not updated at least monthly. Failure to make these monthly updates to its Provider Directories negatively impacts United's beneficiaries' ability to access a full network of providers or to access its provider network in a timely manner.
28. In response to IDR 6, United submitted its BH Delegate's policy titled "IDR 6a_OBH_Clinician Status Updates" to describe its process for updating its Provider Directories. This policy states "When any of the following changes are submitted and do not involve a Tax Identification Number (TIN) change, the directory will be updated within 10 business days: Practice Address; Practice Phone number; Accepting new patients/availability status; Changes to office hours (including evening and weekend availability); [and] Provider name." United's BH Delegate failed to meet the requirements for daily telephonic Provider Directory updates and did not incorporate minor changes to provider demographics in its Provider Directory within seven business days.
29. In response to IDR 6, United submitted an excel file titled "IDR 1-10 Follow Up Responses 12.11.2019" stating that "UnitedHealthcare usually completes requested updates within 30 days." The Examiners followed up with IDR 6.2, requesting the written policy that verified the 30-day timeframe. In response,

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United stated, "UnitedHealthcare usually completes requested updates within 30 days, subject to individual state requirements. Those timelines are highlighted on page 2 of the attached policy, which for RI is 7 days." This United policy, titled "Escalation Process for Provider Adds and New Contracts Job Aid," reflects on its face that the 7-business day turnaround time required by Rhode Island for minor changes was not effective until June 13, 2019. When United receives these changes to provider information there is no evidence that there is a mechanism in place to ensure that these changes are incorporated into the Provider Directory in order to ensure daily telephonic updates.

30. In IDR 23.4 the Examiners asked United if it maintains a separate log that tracks minor provider credentialing/re-credentialing changes including, but not limited to, changes of address and changes to a health care provider's TIN. In a response document titled "Responses to Follow Ups on IDR 11-24 Final 1.8.20" United stated the following: "UHC does not track these changes from a credentialing/recredentialing process. There are some changes that can be made if identified during the recredentialing process, i.e. SSN, DOB, license issues, etc. but there is not a separate log kept to track these changes made during the recredentialing process." United also provided a response from its BH Delegate which stated "Processing minor provider changes are not always a part of the re-credentialing process. If there is a discrepancy of demographic

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information identified during the re-credentialing process, the provider is sent a letter requesting the information and directing the clinician to submit a request to update the information. That request is submitted to and handled by the Provider Data Maintenance Team. Discrepancies identified involving SSN, DOB, license issues, etc. would be addressed during the re-credentialing process. There is not a separate tracking log for these changes." Given that United and its BH Delegate do not maintain a separate tracking log of these minor changes as part of its re-credentialing process the Examiners conclude that United and its BH Delegate do not incorporate minor changes received through the re-credentialing process to update its Provider Directories in compliance with Rhode Island statutes and regulations and as a result are also not complying with the Rhode Island requirement to make daily updates to its Provider Directory available telephonically to beneficiaries.

31. Conclusions of Law. Based on the findings in Paras. 28–30 United and its BH Delegate violated the requirements set forth in R.I.G.L. § 27-18.8-3 (c) (4) and 230-RICR-20-30-9.7 (D) (4) to make daily updates to its Provider Directory available telephonically to beneficiaries and providers. Failure to make available daily telephonic updates to its Provider Directories negatively impacts United's beneficiaries' ability to access a full network of providers or to access its provider network in a timely manner.

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32. In response to IDR 8, which requested a list of all internal audits, compliance reviews, and external audits conducted, United provided a document titled "PDA Validation Reports-RI-2019" which included reviews of its M/S Provider Directory accuracy and a more limited review of its BH Delegate's Provider Directory accuracy. In response to IDR 8.2 United submitted a response document titled "IDR 1-10 Follow Up Responses 12.11.2019" which stated, "The quality program is UnitedHealth Group wide and includes all Provider Types (Medical, Optum BH, Optum PH, Dental and Vision). OBH does not do separate testing." However, in IDRs 25 and 26, United provided information on its BH Delegate oversight and its quality assurance programs for delegated activities. As specifically stated in this oversight document titled "UHC-RI MCE Optum Interview_Delegate Oversight IDRs Responses 1.8.2020_Fi" the BH Delegate does indeed conduct oversight testing stating that "Optum also conducts monthly provider directory audits of a sample of clinicians to validate directory-related data. For its part, Optum employs a team responsible for the management of the behavioral health care provider network and the maintenance of provider information made available to members and prospective members. The Manager of Behavioral Health Care Provider Operations at Optum is responsible for the management and oversight of the behavioral health care provider directory and all methods used to present

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behavioral health care provider directory information to covered persons. For its part, UnitedHealthcare's Director of Provider Service within Operations hosts monthly meetings with UnitedHealthcare and Optum participants for Optum Behavioral Health, where an overview of provider data attestation and accuracy activities across both areas is shared and discussed." Though United has monthly meetings with its BH Delegate to discuss the BH Delegate's Provider Directory accuracy results, it did not provide a comprehensive set of these monthly meeting minutes when requested by the Examiners rather a document was provided titled "Meeting Agenda/Minutes". The information in this document was cryptic and uninformative. The Examiners concluded that United did not keep adequate records of this one meeting and did not provide evidence of any other meetings held during the Exam Period.

33. In IDR 7 the Examiners' requested that United provide its policies, procedures and controls for validating the information contained in the Provider Directory. In documents titled "IDR 7_OBH_Prov Demo Validation Program" and "IDR 7_OBH_Prov Directory Accuracy", Examiners found that United did not provide sufficient documentation to ensure that it has procedures and controls to check the accuracy of its BH Delegate's Provider Directory in terms of the accuracy of its non-professional provider information. Examiners concluded that United failed to develop, implement and maintain a quality assurance program that

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oversees the Provider Directory accuracy activities of its BH Delegate. The information submitted in documents and interviews by United also indicated that it is unaware of its BH Delegate's independent efforts to test its Provider Directory's accuracy so noted in Para. 32.

34. Conclusions of Law. Based on the findings in Paras. 32 and 33, United did not demonstrate compliance 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), regarding overseeing its BH Delegate to determine the adequacy of its BH network.

35. In response to IDR 9 United submitted its Certificates of Coverage submitted for its Choice HMO and Choice EPO network plans. An email dated October 1, 2020 from United to Examiners states that "Choice HMO is the same as Choice EPO, members have access to our national network". The Examiners reviewed the Choice HMO and EPO Certificates of Coverage and were unable to locate any information on the member's option to obtain services from a provider in United's national network. On October 09, 2020, the Examiners requested additional clarification via email to United regarding how United communicates to its members the availability of its national network and how members access its national provider network listing. In its October 15, 2020 email response to the Examiners United stated that, "When a member needs to locate a participating provider whether in state or out of state they log into myuhc.com

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[myuhc.com] (or they call the customer service number on their card). Once they are on myuhc.com [myuhc.com] and go to the provider search tool, the first prompt they see is 'what location do you want to find a provider in'. Here the member with national network access can search nationwide based on location and specialty, they are not limited to RI. Similarly, if the member already knows the particular provider they want to see in an out of state location, they can do a search for that provider specifically to see if they are in their network." The Examiners reviewed the myuhc.com [myuhc.com] website and there was no indication of any communication of the option to use United's national network. There is no indication that United directly and explicitly makes its beneficiaries aware of their ability to access United's national network on its website or in any coverage documents submitted by United.

36. **Conclusions of Law.** Based on the findings in Para. 35, United is in violation of 230-RICR-20-30-9.7 (D) (2) as United did not evidence that it makes its national provider network directories easily available to consumers and providers in an understandable and reasonably comprehensive format. Based on the findings in Para. 35, United is also in violation of 230-RICR-20-30-9.7 (D) (3) (b), as it fails to make its national provider directories available to beneficiaries, providers, and the public in printed and paper format.

Provider Directory Recommendations

37. United, including its BH Delegate, shall implement the following recommendations in order to remediate the non-compliant practices found by the Examiners and as described in Paras. 26–36. On or before January 31, 2023, United shall implement each of the following Provider Directory Recommendations set forth in Paras. 38–41 and further implement the Provider Directory Recommendations outlined in Paras 42 and 43 by the dates specified..
38. United shall establish Rhode Island specific policies and procedures to assess and maintain an accurate Provider Directory to include the following:
- A. Consistent and compliant timelines for the accurate updating of electronic, paper and telephonic Provider Directories, including the requirement that accurate daily updates be made available telephonically;
 - B. Policies to ensure that employees responsible for responding to telephonic inquiries for Provider Directory information have access to and utilize a database that is accurately updated daily; and
 - C. A revised process for effectively auditing the accuracy of its Provider Directories and correcting identified deficiencies. This process shall include at a minimum: periodic direct communication with INN providers to audit and ensure directory accuracy; auditing of a comprehensive number of providers

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and provider types, to include BH Delegate providers; mechanisms for ensuring Provider Directory accuracy across all provider types; and the systematic use of data-driven information (e.g., claims, complaints, inquiry logs, credentialing, contracting) to inform and evaluate directory accuracy and compliance. This process shall also include mechanisms to correct identified deficiencies, improve upon directory error rates and document said corrections and improvements.

39. United shall establish a process to explicitly communicate to consumers and providers, in writing, the availability of United's national network to its Rhode Island sitused national network plans. Such communication shall include pre-enrollment and post enrollment documents as well as information on myuhc.com.
40. United shall make available, upon request, to all beneficiaries, providers, and the public (requester) a printed and paper copy of its provider directory to include its national network if applicable, unless otherwise agreed to by the requester to accept a modified printed and paper copy of its provider directory.
41. United shall review its current Rhode Island specific audit program to ensure that it has an established ongoing audit mechanism for any and all Delegates responsible for Provider Directory updates to ensure compliance with R.I.G.L. § 27-18.8, 230-RICR-20-30-9.5 (B) (1), and the recommendations issued in this

Examination report. United shall create a Rhode Island specific standard training operating procedure and a training process that includes the revised policies and procedures noted in Para. 38 and provide necessary ongoing training for staff whenever policies and procedures are revised and on a periodic basis no less than annually.

42. On or before June 1, 2022, United shall conduct a statistically valid Rhode Island specific Provider Directory audit acceptable to the Commissioner, in accordance with Para. 38 (C) and provide OHIC with the report by August 1, 2022 summarizing and certifying that this audit was conducted in accordance with Para. 38 (C) as well as setting forth the results of the audit and United's plans for addressing any identified deficiencies revealed in the audit.

43. On or before June 1, 2022, United shall submit to the Commissioner for approval a master data management plan that actively works towards the reconciliation of disparate provider information received by United and its BH Delegate. The objective of United and its BH Delegate's master data management plan shall be to create a more accurate source of up-to-date INN Provider Directory information.

Network Adequacy Findings and Conclusions

44. The Examiners reviewed United's responses to the IDRs identified in the below paragraphs (the specifics of each IDR request and response, including follow

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up requests and responses, can be found in Appendix A) as well as the interviews conducted with United staff. The Examiners findings and conclusions are as stated in Paras. 45–75.

45. In IDR 16, the Examiners requested documentation of United's approach and methodology in determining the adequacy of its provider network including network tiers to include measurements, parameters, goals, and identified network gaps. United responded with the submission of a document titled "Network Adequacy Accessibility Report_RI.xlsx" to evidence how it evaluates and determines its Network Adequacy. According to the Network Adequacy Accessibility Report 29 M/S provider types, but only four BH provider types,⁸ are monitored for adequacy in United's network. United's IDR 12 response provided a document labeled "IDR 12_OBH_Prov Access Standards_final.pdf," which included several BH provider types that were not in any of United's Network Adequacy monitoring reports that were submitted in response to IDR 16. In response to IDR 25.2, United stated, "From a network adequacy perspective, UnitedHealthcare evaluates and monitors Optum network adequacy and provider availability on a monthly basis. At the request of United network adequacy reports are generated by Quest Analytics (external vendor,

⁸ The four BH provider types are: Inpatient Psychiatric Facility Services, Licensed Clinical Social Worker, Psychiatrists, Psychologists.

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not to be confused with our internal QuEST team) and shared with Optum.” The Quest Analytics reports indicate that United only tested for the four BH provider types included in the IDR 16 response and did not include the provider types previously noted in its submitted response to IDR 12.⁹

46. In response to IDR 26.2, United provided a document labeled “UHN E and I Network Adequacy and Filing 2019.07.18.doc,” which indicated that United and its BH Delegate met on July 19, 2019, to discuss Quest Analytics’ reports on the variations and gaps in the provider network. As part of United’s response to IDR 25 and 26 a document titled “UHC-RI MCE Optum Interview_Delegate Oversight IDRs Response 1.8.2020_FI” was submitted and stated on page 3, “Adequacy reports are not requested of Optum by UnitedHealthcare.” As noted in Para. 45, at the request of United, network adequacy reports are generated by an external vendor and then shared with United’s BH Delegate as part of United’s oversight and monitoring. The Examiners reviewed those reports and concluded that United did not demonstrate sufficient oversight of the adequacy of its BH Delegate’s network, given the limited number of BH providers

⁹ IDR 12 BH provider types include: Prescribers identified as MD, DO, Nurse Practitioner, Physician’s Assistant, Medical Psychologist, Doctoral Level Clinician, Master’s Level Clinician, Child/Adolescent clinician (Prescriber, Doctoral and Master’s Level), Acute Inpatient Care (mental health and substance abuse), Intermediate Care (mental health and substance abuse), Partial Hospitalization (mental health and substance abuse), Residential (mental health and substance abuse), Intensive Outpatient Care (mental health and substance abuse) and prescribers with an expertise in Medication Assisted Treatment.

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reviewed and its failure to review and assess the full scope of its compliance with its own access standards.

47. During the Exam Period, and as submitted by United in response to IDR 20, 16 members requested and were approved for single case agreements (SCA) by United's BH Delegate to receive services from an OON provider at the INN benefit level. The services requested included the following: mental health services by a non-physician, mental health assessments by a non-physician, mental health therapeutic behavioral services, mental health day treatment, methadone treatment programs, and mental health intensive outpatient services for adults. Though these requests were approved, United did not provide evidence that it considered including these OON provider types as part of its audit and evaluation of Network Adequacy. Further, United continued to test only those four BH provider types noted in the reports generated by Quest Analytics and as described in Para. 45.

48. Conclusions of Law. Based on the findings in Paras. 45–47, the Examiners have determined that from January 1, 2019, to August 31, 2019, United was in violation of R.I.G.L. § 27-18.8-3 (c) (2) and 230-RICR-20-30-9.7 (B), as it was not overseeing or reviewing the quarterly Network Adequacy monitoring, testing and audit activities performed by Quest for its BH Delegate. United also failed to perform the required quarterly Network Adequacy monitoring of its BH

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Delegate's network of providers, including monitoring the specified provider types for BH services that are listed in United's policy and Network Adequacy monitoring program. Further, United failed to implement and maintain a quality assurance program that included the oversight of all its delegated BH activities, which is in violation of R.I.G.L. § 27-18.8-3 (b). Finally, United did not have a process to ensure that all BH activities (including Network Adequacy monitoring) were performed in a manner that maintained the quality of services for its beneficiaries or ensure that those activities did not adversely affect the delivery of covered services in violation of 230-RICR-20-30-9.6 (E).

49. The Examiners reviewed United's response to IDR 11 requesting policies, procedures and standards used by United to admit providers to its networks. This response included a document titled "NCC Process Flow Rhode Island Cred 03112019 (1)" that showed the workflow used by United in processing credentialing and re-credentialing applications. The workflow identifies an application as complete only after the information on the application has gone through a primary source verification. Further, in an IDR 22 response document titled "United Behavioral Health Clinician and Facility Credentialing Plan," United's BH Delegate states, "Verifications, including application attestation, are completed within one hundred-eighty (180) calendar days from the time of the Applicant's signature to the time the Credentialing Committee makes its

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recommendation." Further in an IDR 22 response document titled "Clinician Credentialing Process", United's BH Delegate states "Primary source verifications commence once a complete application packet has been received. All written credentialing documentation must be in ink that is not erasable. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. The verification process does not include any questions regarding the clinician's race, ethnic/national identity, religion, gender, age, sexual orientation or the types of patients the clinicians sees. The following elements are verified or reviewed for each applicant within 180 calendar days prior to the Credentialing decision." The United and BH Delegate documents presented evidence that United and its BH Delegate do not identify when an application is complete in accordance with Rhode Island requirements and thereby do not adhere to the additional Rhode Island requirement to communicate credentialing and re-credentialing decisions within 45 calendar days of receipt of a completed application. United begins the 45-calendar-day count only after it has taken time to verify the information on a completed application and its BH Delegate allows 180 days from receipt of the completed application to complete and communicate its credentialing and re-credentialing decision to the applicant.

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50. Conclusion of Law. Based upon findings in Para. 49, United did not utilize the correct start date for the receipt of a completed credentialing and re-credentialing application and did not set compliant policies and procedures that adhere to the 45-calendar-day notification requirements in violation of R.I.G.L. § 27-18.8-3 (d) (2) (i), 230-RICR-20-30-9.8 (D) (1-8), R.I.G.L. § 27-18-83, and 230-RICR-20-30-9.8 (A) (3) (a).
51. The Examiners reviewed United's response to IDR 23.3, which included its BH Delegate's credentialing and re-credentialing log labeled "IDR 23.3_RI OHIC_Clinician Universe.xls." The Examiners identified that in three of the 127 total BH credentialing applications logged on this internal document, United failed to inform the applicant of its credentialing decision within 45 calendar days of receipt of what United considers a completed application. Based on United's re-credentialing logs, its BH Delegate issued 232 re-credentialing decisions and it failed to notify ten applicants within this 45-calendar-day requirement (these late notifications ranged from 49 to 119 days). The Examiners also found that for all 359 credentialing and re-credentialing applications, United and its BH Delegate failed to identify a completed application according to Rhode Island requirements. The Examiners concluded that a greater number of United's BH Delegate's provider applicant decision notifications went beyond the three BH credentialing and ten BH re-

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credentialing application decisions noted above, were outside of the 45-calendar-days from receipt of completed application (as that term is defined in Rhode Island law).

52. The Examiners also reviewed United's updated M/S credentialing and re-credentialing transactions submitted in response to IDR 23.3, which were provided within the document labeled "Copy of Copy RI_EI_100419 (3). Revised 1.8.2020." The information provided by United failed to demonstrate that United notified providers of its credentialing and re-credentialing decisions for any of the 1,222 applications received during the Exam Period within 45 calendar days of receipt of a completed application, as defined by Rhode Island law (See Paras. 49 and 50). Even based on United's definition of a completed application and the dates application decisions were communicated, the Examiners found that 278 were made beyond a 45-calendar-day turnaround time. Given that United did not correctly identify a completed application according to Rhode Island requirements (See Paras. 49 and 50), the Examiners conclude that 1,222 timeline violations occurred during the Exam Period.

53. Conclusion of Law. Based on the findings in Paras. 51 and 52, United and its BH Delegate did not communicate United's credentialing and re-credentialing decisions to applicants within 45 calendar days after the date of receipt of the

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completed application, thereby violating R.I.G.L. § 27-18-83 (a) and 230-RICR-20-30-9.8(A) (3) (a). Failure to promptly process credentialing and re-credentialing applications affects United's beneficiaries' ability to access services from INN providers. The above cited failures by United around credentialing and re-credentialing timelines further caused United and its BH Delegate to violate the spirit and purpose of 230-RICR-20-30- 9.8 (7), which requires providers to be granted billing privileges no later than one business day after approval of their credentialing and/or re-credentialing application.

54. The Examiners reviewed the information from United regarding its BH Delegate's credentialing and re-credentialing activity, which was detailed within a document labeled "IDR 23.3_RI OHIC_Clinician Universe.xls." Upon review of this information, the Examiners identified two credentialing applicants and 22 re-credentialing applicants in which United failed to inform the BH provider of missing application materials within 15 calendar days. Additionally, the Examiners reviewed United's M/S provider network, which was detailed in an updated document submitted by United and labeled "Copy of RI_EI_100419 (3). Revised 1.8.2020," to evaluate its compliance with updating M/S providers every 15 days of their application status. However, in this document United failed to provide certain categories of requested information. As a result, the Examiners were not able to evidence United's compliance with 230-RICR-20-

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30-9.8 (A) (5)'s requirement for providing application status updates to its M/S credentialing and re-credentialing applicants every 15 days.

55. Conclusions of Law. Based on the findings in Para. 54, United did not provide a status update to providers/applicants to inform them of missing application materials within the required 15 calendar days, which is in violation of R.I.G.L. § 27-18-83 (d) (1) and 230-RICR-20-30-9.8 (A) (5).

56. In response to IDRs 14 and 16, United submitted policy ID-6365, describing its standards, measured in time, for accessibility to services. This policy addresses both M/S and BH access standards. United's BH Delegate also provided a policy document titled "OBH_Access Standards_Hours of Ops_final.pdf," which contains the same BH standards noted in United policy ID-6365. The BH Delegate's policy indicates that the time standard for BH access to follow-up routine care with prescribers is less than or equal to 60 calendar days. United further indicates that its BH access standards for follow-up routine care with BH non-prescribers is less than or equal to 30 calendar days. The standard generally applicable to M/S services for regular/routine care is 14 days. Moreover, United does not differentiate its M/S standard based on the provider's license to prescribe. These standards, presented by United and its BH Delegate, are different than the standards applicable to M/S service access.

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57. In response to IDR 16, United submitted its Network Adequacy availability standards, which use provider to member ratios (herein after provider to member ratios will be referred to as Ratios). United's BH Ratio for doctoral-level providers who prescribe medications is a 1:2000 ratio, meaning there should be at least one provider available for every 2000 members. United's BH Ratio for providers who have a master's level degree or are child adolescent clinicians (MD, PHD, and Master's-Level), a 1:1000 ratio is utilized, meaning there is one provider available for every 1000 members. United's standards applicable to M/S are different from those for BH, as its standards are not based on prescribing privileges or degree level but appear to be based on practice type. United includes M/S provider standards for General Practice, Family Practice, Internal Medicine, Pediatrics, and Geriatrics, all of which have a 1:1000 ratio, meaning there should be at least one provider per 1000 members.

58. In its IDR 16 response, United also included specialty providers within its INN outpatient classification for M/S provider standards, which it established to monitor and ensure the availability of these specialty providers for specific M/S conditions¹⁰. For BH providers United does not consider sub-specialties

¹⁰ Based on United's submitted IDR 16 excel document titled "Network Adequacy Accessibility Report_RI" these M/S categories are: Allergy & Immunology, Cardiology, Dental, Dermatology, Diagnostic Radiology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Infectious Diseases, Neurology, Nephrology, OB/GYN, Oncology, Ophthalmology, Orthopedics, PCP, Pulmonology Rheumatology, Pulmonology, and Urology.

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including, but not limited to, Child and Adolescent Psychiatry, Geriatric Psychiatry, Addiction Psychiatry, Psychology, Licensed Professional Counselors, Board Certified Behavior Analysts, License Marriage Therapists, Licensed Clinical Social Workers, Certified Alcohol and Drug Counselors, Psychiatric/Mental Health Nurse Practitioners, and Psychiatric/Mental Health Nurses. United's categorizations for BH providers are broad, as they focus on degree level and prescribing privileges and are different from the M/S provider categorizations.

59. In response to IDR 16, United indicated that BH facility providers of Intermediate Care/Partial Hospitalization/ Residential, Intensive Outpatient Care, and Medication Assisted Treatment have a 1:20000 (one to twenty thousand) provider-to-member ratio. In contrast, M/S providers of Hospitals and Ambulatory Surgery Centers have a 1:5000 (one to five thousand) provider-to-member ratio. Also, United's response to IDR 10 referenced that members encountered accessibility barriers for services when requesting higher levels of care for BH conditions. A review of the information within IDR 20 shows that members requested access to OON intensive outpatient facilities for adults and OON outpatient facilities that offer medication-assisted treatment, specifically methadone treatment, because there were no available INN providers. United approved those requests. For these higher levels of BH outpatient care, there

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was a difference between the member to provider ratios utilized for BH providers and those utilized for M/S providers.

60. In response to IDRs 14 and 16, United submitted policy ID-6327 to address the distance standards and numeric distribution of INN practitioners and providers specific to M/S services. Additionally, United submitted the "Optum" policy PA.01 (BH Provider Access Standards) to address the distance standards and numeric distribution of INN practitioners and providers specific to BH services. In miles, the distance standards for BH Intensive Outpatient Care and BH Intermediate Care/Partial Hospitalization/Residential are 15 miles for large metros, 45 miles for metros, 75 miles for micro and rural areas, and 140 miles for counties with extreme access conditions (CEAC). By comparison, United's distance standards for M/S, in miles, vary depending on whether they are for higher levels of care or specialty care and range from 5–10 miles for large metros, 10–30 miles for metros, 20–60 miles for micros, 30–90 for rural areas, and 60–130 for CEAC. Thus, United's distance standards for BH access are different from United's standards for M/S service access.

61. In response to IDRs 14 and 16, United submitted policy ID-6365, describing its standards, measured in time, for accessibility to services. This policy addresses both M/S and BH access standards. United's BH Delegate also provided a policy document titled "OBH_Access Standards_Hours of Ops_final.pdf," which

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contains the same BH standards noted in United policy ID-6365. United policy ID-6365 indicates that the time standard for BH access to urgent care is 48 hours, but the time standard for M/S access to urgent care services is the same day (or 24 hours). Also, 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.

62. The standard document applicable to the BH provider-type "acute inpatient care" presented in response to IDR 16 titled "Behavioral Health Provider Access Standards Policy Identifier Number: PA 01B" indicates a 1:20000 ratio, meaning one provider is available for every 20,000 members. For M/S inpatient service providers, including hospitals and skilled nursing facilities, a 1:2500 ratio is utilized, meaning one provider is available for every 2500 members.
63. In IDR 16, United submitted a document titled "IDR 12_OBH_Prov Access Standards_Final" which included the distance standards for acute BH inpatient care: 15 miles for large metros, 45 miles for metros, 75 miles for micro and rural areas, and 140 miles for CEAC. By comparison, within IDR 14 United submitted a document titled "Availability of Practitioners and Providers" identifying its distance standards for hospitals and skilled nursing facilities are 10 miles for large metros, 30 miles for metros, 60 miles for micro and rural areas, and 100

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miles for CEAC (except for skilled nursing facilities which have a distance standard of 85 miles for CEAC)¹¹.

64. In response to IDR 16, United's policies state that a practitioner designated in a High Impact Specialty (HIS) is "a type of specialist who treats special conditions that have serious consequences for the member and require significant resources." It also states, "top HIS are identified, at least annually" with "oncology/hematology and cardiology ... defined as HIS for all plans." United's policy also indicates that "HIS are identified using mortality data derived from Centers for Disease Control (CDC) website... [and] on an annual basis, the top two (2) causes of mortality reflected in the line of business's product's pertinent age bands are reviewed and practitioner types associated with treatment of disease related mortalities are identified." United uses the Center for Disease Control's (CDC) data to assist in the assignment of HIS practitioners. According to the CDC mortality charts, suicide is listed as the number two leading cause of death for individuals between the ages of 10 and 34. However, it does not appear that United automatically assigns HIS status to the practitioners that treat BH disorders. United uses this HIS testing methodology to specifically test the Network Adequacy of network plans and ensure members have timely

¹¹ The Examiners note that United's BH Delegate modified its written access standards on February 27, 2019, increasing the distance standard for BH, which could have potentially resulted in members having to drive even further to BH service providers. There was not a supplementary explanation for this change.

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access to HIS providers, but United does not apply this HIS methodology for BH providers and, therefore, does not effectively address all HIS network issues.

65. **Conclusions of Law and Statement of Concern.** Based upon Para. 56– 64 the Examiners conclude that United's BH urgent care access standard of 48 hours is in violation of the Rhode Island urgent access requirements which requires care within a 24-hour period pursuant to 230-RICR-20-30-14.3 (A) (39). Further, the Examiners note, the following statements of concern. The Examiners note a concern, that pertaining to United's Network Adequacy standards for BH services, including its provider-to-member-ratios, geographic availability distances (measured in miles), accessibility to services (measured in time), and the designation of HIS care practitioners, were different from those standards set for M/S providers and these disparate standards may result in more limited access to BH providers for beneficiaries.
66. United's M/S Emergency Service standards (Policy ID 6365) calls for immediate access to emergency services. However, for BH emergency service standards, United makes the distinction between Emergency and Non-Life-Threatening Emergencies when applying appointment wait-time standards and employs a 6-hour standard for access to "Non-Life-Threatening" BH Emergency

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Services. Thus, United's BH emergency timeframe service standards are different from its M/S emergency standard.

67. Statement of Concern. Based on the findings in Para. 66, the United BH Delegate's access standard definition used for BH emergency care is 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) .

68. The Examiners analyzed the claims data in Procedure Code Table 1, Tab 3 (Appendix C). United did not submit information to separate professional procedure codes from facility procedure codes. Therefore, the Examiners reviewed the combined professional and facility procedure code claims data. Tab 3 of this table includes 202,892 professional and facility procedure code claims with 143,541 (70.7%) of these claims identified as M/S and 59,351 (29.3%) identified as BH. Of the total procedure code claims analyzed, 27,014 (13.3%) were identified as OON, with 19,847 (73.5%) of the total OON claims identified as M/S OON claims and 7,167 (26.5%) as BH OON claims. The following categories of services had more than 20% rendered OON: chiropractic; therapeutic; home infusion; dialysis; BH community support; mental health; and substance use services (See Appendix C, Tab 3 Procedure Code Table 1 column H for details). The Examiners note that United approved an average of 70.5% of all OON claims.

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69. The Examiners further analyzed the claims data identified in Para. 68 to determine what specific diagnostic categories were linked to these M/S and BH OON claims. Procedure Code Table 2, Tab 2 provides more diagnostic detail on the OON claims found in Procedure Code Table 1, Tab 3 after filtering the claims data to only include diagnostic categories with at least six OON claims (more detail provided in Appendix B). Upon review of the 129,061 filtered procedure code claims (INN and OON) found in Professional Table 2, Tab 2 the Examiners identified 76,089 (59%) as M/S and 52,972 (41%) as BH. Of the total procedure codes analyzed in Professional Table 2, Tab 2, 25,076 (19.4%) were identified as OON claims, 17,748 (70.8%) of which were M/S OON claims and 7,328 (29.2%) of which were BH OON. The Examiners then broke down these "six or more" filtered OON claims by diagnoses to reveal the following diagnoses:

musculoskeletal pain and injury diagnoses related to chiropractic and therapeutic services; mitochondrial metabolic disorders, spondylosis without myelopathy or radiculopathy lumbosacral region, chronic pain and sepsis for home infusion services; end stage renal disease for dialysis; developmental disorders, ADHD and autism for BH Community Support services; and anxiety, adjustment disorders, major depression, alcohol use and opioid use for BH services. Of the total M/S and BH OON claims identified in Procedure Code Table 2 Tab 2 70.2%

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were approved. See Procedure Code Table 2 in Appendix C for additional information to support these findings.

70. Based on the data analysis of procedure codes claims described in Paras. 68 and 69 and the additional data analysis detailed in Procedure Code Tables 1 & 2 (Appendix C), the Examiners conclude that this claims data could potentially indicate network inadequacies. Though OON services were approved at a high rate, 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, which may result in the unexpected financial burden of paying for these services.

71. The Examiners analyzed, filtered and sorted the claims data in Revenue Table 1 (Appendix D). Tab 4 of this table shows a total of 31,589 revenue-code-based facility claims, with 29,568 (93.6%) of these claims identified as M/S claims and 2,021 (6.4%) identified as BH claims. Of the total revenue code-based claims analyzed, 2,721 (8.6%) were identified as OON, 67.6% of which were M/S OON claims and 32.4% of which were BH OON claims. Further analysis of the claim subset in Appendix D, the Examiners found that a disproportionate number of OON claims were for BH. Of the total BH revenue code-based claims, 43.6% were OON, whereas 6.2% of the total M/S revenue code-based

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claims were OON. Of the total BH revenue code-based claims 16.4% of the BH OON claims were ultimately denied, compared to only 3.6% of the total M/S revenue code-based claims identified as OON M/S denied claims. Of the M/S claims that were rendered OON, dialysis services (Revenue Codes 821 and 851) stand out as having the largest OON M/S claims proportion at 58.8%. Of the B/H OON claims, Intensive Outpatient (IOP), Partial Hospital (PHP), Residential Treatment Room/Board, and Detox Room/Board make up the largest proportion of OON BH services at 36.6%, 22.1%, 22.0% and 12.5% respectively. There was also disproportionately more BH claims that were denied when occurring OON compared to M/S. An average of 49.1% of all OON claims were approved.

72. The Examiners further analyzed the claims identified in Para. 71 to determine what specific diagnostic categories were linked to M/S and BH OON claims. Revenue Table 2, Tab 2 further filters the claims found in Revenue Code Table 1, Tab 3 by only including the diagnostic categories with at least six OON claims. The Examiners found that Revenue Table 2 Tab 2 shows a pattern similar to the one noted in Para. 71, wherein a disproportionate number of OON claims were for BH. The total number of revenue code-based claims analyzed in Revenue Table 2, Tab 2 was 4,357, with 2,799 (64.2%) identified as M/S claims and 1,558 (35.8%) identified as BH claims. Of the total revenue code-

based claims analyzed in this table, 2,384 (54.7%) were identified as OON claims, 63.4% of which were M/S OON and 36.6% of which were BH OON. A breakdown of the diagnoses associated with these OON revenue code-based claims reveals that dialysis for end stage renal disease was the primary M/S OON diagnostic category accounting for 71.6% of the total OON M/S claims. The Examiners also found that services at most levels of BH care (IOP, PHP, Residential and Inpatient) were primarily for substance use disorders (81% of the BH OON claims). Alcohol and opioid use were the predominate substance use disorders. See Revenue Code Table 2 in Appendix D for additional information to support these findings. Of all OON claims in Revenue Table 2, United approved on average 45.2% of these claims.

73. Based on findings in Paras. 72 and 73 and the additional data detailed in Revenue Code Tables 1 and 2, the Examiners found that the claims data could potentially indicate network inadequacies for dialysis and for most levels of care for substance use disorders. The Examiners also found that there was a disproportionately higher number of services rendered OON for BH services than for M/S services. 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.

74. The Examiners further analyzed the procedure code and revenue code claims tables (Appendix C and D) to determine the average percentage of OON claims denied. The Examiners found that on average the number of OON procedure code claims on Procedure Code Tables 1 and 2 that were denied as a percentage of the total procedure code claims was 4.9% and as a percentage of total OON procedure code claims it was 29.7%. 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 17.2% and as a percentage of total OON revenue code claims it was 52.9% (See Revenue Table 2 Tab 3 for this data summary). The Examiners concluded that United 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 United may not fully protect the beneficiary from balance billing by the OON provider beyond what the beneficiary is liable for in-network. In addition, not having a sufficient number of INN providers to render clinically necessary services may cause United beneficiaries to either not seek care or delay care due to the potential for additional financial risk if obtaining care from an OON provider.

75. Conclusions of Law and Statement of Concern. Based on the findings in Paras. 68-74, United is in violation of 230-RICR-20-30-9.6 (E), as it did not maintain sufficient policies and procedures to identify network inadequacies. The Examiners also note their concern that there may be network inadequacies within United's network, including in BH service categories.

Network Adequacy Recommendations

76. United and its BH Delegate shall implement the following Recommendations in order to remediate the non-compliant patterns and practices found by the Examiners and described in Paras. 45-75. On or before June 1, 2022, United shall implement each of the following Network Adequacy recommendations set forth in Paras. 77-81.

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

- A. A revised policy and mechanism to effectively determine whether its network is sufficient in volume and scope, such that its beneficiaries can obtain needed covered benefits. This policy shall include the use of claims, complaints, appeals, wait-times, time and distance standards, member to provider ratios and other provider and consumer data to identify and then actively initiate efforts that minimize its network deficiencies. This policy shall also include a process to identify and document the reasons for identified

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network deficiencies and document United's efforts to resolve the underlying issues that lead to network inadequacies;

- B. A process to conduct quarterly reviews of its Network Adequacy activities, including those of its BH Delegate, in accordance with 230-RICR-20-30-9.7 (B), and to report the results of these quarterly reviews to OHIC, for the next five years or a shorter duration as determined by the Commissioner, and thereafter upon request by OHIC.
- C. A revision of its credentialing and re-credentialing policy and the establishment of a process and an audit mechanism that ensures compliance with the timelines and requirements set forth in R.I.G.L. § 27-18-83, R.I.G.L. § 27-18-83, 230-RICR-20-30-9.8 (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 access standards are maintained for both BH and M/S providers in a manner that ensures timely access without unreasonable delay or distance. Where the time and distance standards and/or provider to member ratio standards maintained for BH providers differ from the standards maintained for M/S providers, substantiate on an annual basis in a report to OHIC, for the next five years or a shorter duration as determined by the Commissioner, that any

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- differing BH and M/S access standards nonetheless ensure consumer access to needed services without unreasonable delay or distance¹².
- E. A revision of the policies and procedures for access standards to ensure that access standards for both prescribing and non-prescribing providers are maintained in a manner to ensure timely access to these providers without unreasonable delay or distance. Where the access standards maintained for prescribing and non-prescribing providers differ, substantiate on an annual basis in a report to OHIC, for the next five years or a shorter duration as determined by the Commissioner, that any differing access standards for prescribing and non-prescribing BH or M/S providers nonetheless ensure consumer access to needed services without unreasonable delay or distance.
- F. A revision of the applicable access standards to ensure BH and M/S emergency services are accessible twenty-four (24) hours a day, seven (7) days a week.
78. Create a training document that includes the revised policies and procedures noted in Para. 77 and provide training to the United and its BH Delegate staff responsible for determining Network Adequacy, credentialing/re-credentialing

¹² The reporting recommendation set forth in Paras D and E in no way mitigate United's obligation to ensure network adequacy consistent with Rhode Island law.

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and contracting when any policies or procedures are revised and on a periodic basis no less than annually.

79. Develop an effective plan to investigate and address potential M/S and BH network inadequacies and report on such efforts to the Commissioner. The plan shall include:

- A. Assessing available information, including, but not limited to claims data, to determine the reasons for the use of OON providers in certain service categories, including those categories identified in Paragraphs 71 and 74;
- B. A process to identify, document and prepare an annual report for the next 5 years, or for a shorter period of time, as determined by the Commissioner, setting forth the rationale as to why United does not contract with those OON providers who are providing medically necessary services to United's beneficiaries, which report(s) shall be made available to OHIC upon request.
- C. A process to expand the use of telemedicine and other innovative delivery system options to assist in the de-escalation of beneficiaries' BH issues to avoid the need for higher levels of care.

80. Revise its quality assurance program and oversight programs to include:

- A. Ongoing oversight of its BH Delegate to ensure its compliance with Network Adequacy mandates and regulations and these Network Adequacy recommendations; and

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B. A process to review activities, including contracting, credentialing, and any process that may negatively impact BH parity, when developing and maintaining its provider network.

81. On or before September 1, 2022, United 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 United's plan to address minimizing any network inadequacies set forth in Para. 79.

Obligation to Facilitate the Examination: Findings and Conclusions

82. Throughout the course of the examination the Examiners experienced challenges in obtaining complete and accurate information from United in response to the IDR's.¹³ Examiners contend that their requests were clear and concise and note that United was afforded the opportunity to ask questions at any time about any requests that were not understood or where United had uncertainty. Further, prior to the examination review commencing, United was provided the opportunity to meet with Examiners to discuss the requests. Based on questions received from all Carriers, a Q&A document was sent to United to address areas of uncertainty. United, submitted responses that were deemed insufficient by the Examiners, inaccurate and/or incomplete. The

¹³ The Examiners note that these repeated failures to provide complete and accurate responsive information occurred despite the fact that United was frequently granted additional time to provide responses to the IDR's.

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experience of receiving insufficient, inaccurate and/or incomplete responses from United prompted the Examiners to review the pattern and quality of United's responses to the IDR's identified in the below paragraphs (the specifics of each IDR request and response, including follow-up requests and responses, can be found in Appendix A) as well as the interviews conducted with United's staff to assess whether United facilitated the examination and aided in the examination so far as it was in their power to do so. The Examiners' findings and conclusions are set forth in Paras. 83-98.

83. In response to IDR 4, which requested an excel listing of all providers within United's network during the Exam Period, United's BH Delegate failed to include the sub-specialty type of the provider as requested by Examiners. For a majority of the provider listings, United's BH Delegate only indicated whether or not the provider was a part of a "facility" or "group", without indication of the specific sub-specialty type of those facilities or provider groups in order for Examiners to perform their analysis. Accordingly, on January 23, 2020, Examiners requested that United resubmit its BH Delegate's provider listing to include the specific specialty of each provider. United responded to Examiners on January 30, 2020 and stated, "the "specialty/expertise" field is not a required field by Optum. As such there will be some lines indicated as N/A." Upon review of United's second resubmission of its BH Delegate's provider listing,

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Examiners made note of several discrepancies. In addition to missing data elements that were originally submitted in United's first submission, United's latest submission included new providers that were not originally submitted within the first data set and excluded providers that were originally submitted within the first data set. This required Examiners to follow up with United on February 7, 2020 for clarification. On February 14, 2020, United responded, "The incorrect listing was inadvertently provided when the specialty was added to the file submitted on January 30, 2020. We apologize for the confusion. Additionally, the previously submitted provider listing only included in-network providers only. The providers that were termed during the exam review period were not included but have been added now." In addition to this written response, United produced its BH Delegate's third provider directory listing, however the listing submitted continued to not align with OHIC's original request.

84. In IDR 5, the Examiners requested United's current organizational charts for the business and operational units specifically responsible for a number of areas under review. United submitted organization charts but did not provide information in a manner to facilitate a review of the information submitted. In most instances, these charts were missing the name of the entity, the names of the leadership within the organizations that were referenced, and the dates that

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the documents were created. This required Examiner to follow up and request clarification. Further, on October 23, 2019, Examiners sent United a document titled "OHIC EXAMINATIONS CARRIER QUESTIONS ANSWERS sent to Carriers 10 23 19.doc". This document provided United with an example of what a functional organizational chart for the provider directory area would include, however, United failed to provide such detail to Examiners.

85. In IDRs 6 and 6.2, the Examiners requested information and policies regarding United's timeline for Provider Directory updates and changes. A written response, but no policies addressing minor demographic changes, were received. In a subsequent response to the Examiner's request for these policy documents, United sent a policy together with a separate Rhode Island addendum to that policy, however, the Rhode Island policy addendum indicated it was not implemented until June of 2019. Therefore, the submitted Rhode Island policy addendum did not cover the entire Exam Period. United did not openly disclose that the Rhode Island policy addendum was not active during the Exam Period from January thru May of 2019. Further, United did not provide a reason why the Rhode Island policy addendum was not provided in the original response, nor why the individual state requirements were not addressed in the response until follow up by Examiners.

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86. In IDR 8, the Examiners requested United's Provider Directory audit information¹⁴ testing the accuracy of its directories. The Examiners needed to request additional information as no explanation of the audit methodology, or the audit results were provided. United responded to the Examiners follow-up IDR's with general statements and no summary of audit content and how the audit was conducted. No information was provided by United that facilitated the Examiners ability to effectively understand and evaluate the scope and efficacy of United's Provider Directory audits.

87. In IDR 8.7 Examiners requested information regarding any corrective action plans which may have resulted from United's provider directory accuracy audit process but United failed to provide any specific information and instead United generally referenced the process it used when defects are found, its specific and repeated response being that "Corrections are being generated based on follow up conversations with the provider group." This was not responsive to the Examiners' specific follow up request regarding corrective action plans.

14. IDR 8 requested:

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.

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88. In IDRs 10 and 10.1, the Examiners requested United's complaint logs of all the complaints it received during the Exam Period. The initial response from United was incomplete and did not include its BH Delegate's complaints. The Examiner noted complaints that were missing and issued a second request, but United's subsequent response still failed to include all complaints as referenced in Paras. 6-9.
89. In IDR 16, United did not provide documentation that evidenced Network Adequacy testing as requested by the Examiners. The Examiners made additional requests for Network Adequacy monitoring results, but this information was never provided.
90. In IDR 20, the Examiners requested a list of all OON exception requests that were made to United's BH Delegate. The Company reported 16 separate requests that were approved as OON exceptions. Examiner's issued a follow-up request asking United to specify whether United had taken any other measures outside of the approval of the 16 individual OON requests to ensure these services are accessible to all members in a timely manner without unreasonable delay. United did not provide a responsive answer to this question. The Examiners asked for additional information regarding these OON exception requests in IDRs 20.2 and 20.3, including the definition of 100% coverage. However, United did not openly disclose whether members could or

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could not be balanced billed in the absence of a single case agreement¹⁵ until many requests for clarification were made by Examiners. United's response to IDR 20.10 indicates, "If the provider refuses to enter into an SCA agreement, Optum will pay the billed charges at the in-network level and the member would be responsible for any co-pay, co-insurance or cost share. While Optum would expect the provider not to impose any additional member liability/cost Optum does not have control over a provider who is not contracted or does not have an agreement in place to prevent the provider from balance billing."

91. In IDR 21, Examiner's requested workflow chart(s) for United's entire network plan as it relates to 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. While United provided workflow charts for itself it did not provide workflow charts for its BH Delegate, which is also a part of its network. Through IDR 21.1 Examiner's requested clarification regarding the applicability of United's workflow chart to its BH Delegate. United

¹⁵ The Examiners note that in follow up responses to IDR 20 United's BH Delegate did not provide a responsive answer as it did not address the OON exceptions outside of the 16 single case agreements. IDR 20.10 was the final request made by Examiners to address whether balance billing is permitted outside of a single case agreement.

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responded "The flow chart provided is specific to the UnitedHealthcare's process."¹⁶

92. In IDR 30, the Examiners requested that United evidence how it considers and ensures access to Rhode Island mandated benefits when developing, monitoring, and maintaining its network. United did not make an effort to answer this request, and instead provided the following inaccurate non-response "There are no such specific mandates that we are aware of but if there were it would certainly be considered in network monitoring". The Examiners note that Rhode Island state law contains upwards of 60 state specific mandated benefits as well as state law requirements around benchmark plan benefit coverage requirements.

93. In IDR 23.2, in order to obtain United and its BH Delegate's complete credentialing and re-credentialing records inclusive of minor changes for credentialed providers, the Examiners again requested all credentialing and re-credentialing activities for the Exam Period with clarification that such logs should include all activities and minor changes and whether such request was approved or not approved. Examiners found in addition to United not submitting its complete list of credentialing and re-credentialing activities, for its BH

¹⁶ The Examiners made note that in performing an Examination of another Carrier who utilizes the same BH delegate as United, the Examiners found that this other Carrier produced the workflow documents of the same BH Delegate as requested by the Examiners in response to IDR 21.

Delegate, United only provided those credentialing and re-credentialing activities for "approved" providers. The Examiners then followed up with IDR 23.3, but United still failed to provide the six specifically requested missing categories of data for United (not including United's BH Delegate) that were preventing the Examiners from fully assessing United's credentialing and re-credentialing process for compliance with Rhode Island laws and regulations. Examiners issued follow-up IDR (23.4) requesting clarification as to whether United and its BH Delegate maintain logs that identified minor changes for credentialed providers. Again, neither United nor its BH Delegate provided the Examiners with access to this requested information.

94. During the Examination, the Examiners made a follow-up request via IDR 26.4 to obtain the policies and procedures that were in effect during the Exam Period to support United's interview statement that its BH Delegate would process claims at an INN level for 90 days after a provider's network termination. United's BH Delegate's follow-up response retracted this timeline stating it was "...up to one (1) year. Please see attached RI addendum." The Company did not provide an explanation or reason why the Rhode Island addendum was not submitted in the original response to the data call requests regarding compliance with 230-RICR-20-30-9.9 (A) (2) (a) or why United's BH Delegate's staff were unaware of this Rhode Island addendum.

95. The Examiners made an initial request in IDRs 17 and 18 for a list of claims received during the Exam Period for Rhode Island situs policies, both INN and OON claims as well as paid and denied claims. Examiners uncovered a series of important claims data omissions and inaccuracies made by United in its first submission. This caused the Examiners to request that United resubmit correct claims data. United's resubmitted claims data was repeatedly found by the Examiners to continue to evidence important claims data omissions and inaccuracies. In total the Examiners had to ask United on five separate occasions to resubmit correct and accurate claims data information. In an effort to conduct a review of the accuracy of United's IDRs 17 & 18 Version 6 submitted on July 22, 2020 (United Claims Data Version 6), to include the accuracy of the INN and OON provider indicators within each claim line, the Examiners requested a sample of INN provider information for Massachusetts (MA) and RI. In order to assist in this review of claims accuracy, the Examiner's requested and received an update of provider network data (IDR 4) on October 13, 2020, inclusive of all of United's in-network Rhode Island and Massachusetts providers during the period. The Examiner's interfaced the newly submitted IDR 4 information to the Rhode Island and Massachusetts claims contained in United Claims Data Version 6 by National Provider Identifier (NPI). The NPI-based INN provider status in IDR 4 was then

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compared to the INN provider status in the United Claims Data Version 6 by the Examiners. Of the 892,052 Rhode Island and Massachusetts claims in United Claims Data Version 6, 106,424 (11.9%) were categorized as INN providers but were not included in the Rhode Island and Massachusetts IDR 4 submissions. The Examiners concluded that the data reflects an 11.9% discrepancy between the IDR 4 and the United Claims Data Version 6 claims data for INN provider status. The Examiners have concluded that though the United Claims Data Version 6 claims data remained inaccurate, utilizing this United Claims Data Version 6 was likely the more reliable claims database made available to the Examiners because the information was obtained from a centralized database (for more detail see Appendix B). Thus, despite the Examiners efforts, including requesting that United submit an attestation signed by an officer of United attesting to the Accuracy and Completeness of the United Claims Data Version 6 submission¹⁷, the Examiners found that United's United Claims Data Version 6 continued to evidence inaccurate and incomplete claims data. The Examiners conclude that United repeatedly failed to produce accurate claims information, thereby impeding the examination.

¹⁷ On September 03, 2020 Examiner's requested that an officer of United sign and submit the attestation attached hereto as Appendix F attesting to the completeness and accuracy of United's claims data submission. United declined to sign the attestation attached as Appendix F and instead on September 25, 2020 provided its own attestation signed by United's Vice President of Regulatory Financial Operations, a copy of which is attached hereto as Appendix G.

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96. Previously, in connection with OHIC's Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3 (Behavioral Health Examination), an order issued on March 20th, 2020, finding that United failed to comply with its obligation to assist in and facilitate the Behavioral Health Examination in violation of R.I.G.L. § 27-13.1-4 (b). The failures to assist in and facilitate in this Examination were comparable in scope, type, and frequency to the failures identified in the Behavioral Health Examination.
97. As a result of the findings set forth in Paras. 83-96, United caused consistent and regular delays of the examination process. The Examiners were unable to obtain complete and accurate responses from United to their IDR's. For example, United submitted unusable or incorrect claims, complaint, provider listing, and credentialing/recredentialing data. Based on United's pattern of practice, the Examiners find that United did not facilitate and aid in the examination so far as it was in United's power to do so.
98. Conclusion of Law. Based on the findings in Paras. 83-97, United is in violation of R.I.G.L. § 27-13.1-1 et seq. (Examination Act) and R.I.G.L. § 27-18.8-8 (b) (3), that obligate it to facilitate and reasonably cooperate in an examination conducted by OHIC. United failed to provide "timely, convenient" access to the materials, policies, and information necessary to conduct the Examination and did not do

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everything in its "power" to "facilitate" and "aid" the Examination as required by R.I.G.L. § 27-13.1-4 (b) which states, "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". United had the ability and power to ensure that it and its BH Delegate complied with their statutory obligations to facilitate and aid in the examination but did not do so. The Examiners also, therefore, conclude that though they were able to determine clear violations of federal and state statutes and regulations as presented in this MCE report, the full scope and severity of the inadequacy of United's and United's BH Delegate's networks, the inaccuracy of United's Provider Directories, and United's complaint and credentialing process non-compliance were impeded by United and its BH Delegate.

Obligation to Facilitate the Examination: Recommendations

99. Within ninety days from the date the consent order is signed by both parties, United shall submit a plan acceptable to the Commissioner to evidence the steps United will take to address the violations set forth in the report's Obligations to Facilitate Paras. 83- 98. This MCE facilitation plan shall ensure prompt and effective compliance with future Examinations and set forth the changes United will adopt to ensure effective and complete facilitation and assistance in future Rhode Island Market Conduct Examinations.

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Appendix A

Information Data Requests

IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
Company Information and Provider Directory Requests		
1	October 11, 2019	<p>Please provide a written profile of the Company and its affiliates and subsidiaries, and include information regarding the Company history and management structure. This should include the date and location of formation, organizational and structural changes during the examination period through the current date, including Company names, management changes, acquisitions, lines of business, products, legal entity organization and management personnel and functional organization charts.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>
2	October 11, 2019	<p>Please provide a list of the Company's comprehensive major medical individual and group (small group and large group) insurance products, as defined under Rhode Island law, plan networks available to beneficiaries from January 1, 2019 through December 31, 2020 within the state of Rhode Island. Please provide a separate list for all new plan networks that will be introduced during 2020. Please include the following information:</p> <ul style="list-style-type: none"> a. Network Name b. Network ID c. Network Size (based on number of beneficiaries served) d. Indicate the network tiers, if applicable e. Market Served (individual, large group, small group) f. Products Available (as applicable, PPO, EPO, POS, HMO, etc.) g. Servicing Area (as applicable, e.g., all of RI, by county, etc.) h. Will Network be available in 2020? (Y /N)

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		The Period that applies to this request is January 1, 2019 through December 31, 2020.
2.1	December 5, 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 5, 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 5, 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.
2.4	December 5, 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.
2.5	December 5, 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	<p>For each of the networks (and network tiers, if applicable) listed under request #2 (2019 networks only),</p> <ol style="list-style-type: none"> Provide an electronic copy (Excel or Word format) of the corresponding provider directories* as of the date of the current date in which this request is processed by the Company. If the network ID is not clearly listed in the provider directory file, please provide a key to identify which file is associated with each network. Also, please provide an Excel document listing the online web address for access to the 2019 provider directories for each of the identified networks.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<p>*If the provider has more than one location in which services are provided, please include a separate line of data that is applicable to each location.</p> <p>The Period that applies to this request is September 2019, specifically, the date that the carrier processes this request.</p>
3.1	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4	October 28, 2019	<p>For each of the networks listed under request #2, provide a separate <i>Excel</i> document* <u>listing</u> of all providers including the following data fields:</p> <ol style="list-style-type: none"> Provider Name Provider NPI Regarding all type 2 NPIs (health organizations such as physician groups, hospitals, nursing homes, clinics, etc.), please include the type 1 NPIs and names (individual health providers such as physicians, licensed clinical social workers, etc.) for the individuals associated with the health organization. Provider Address including Zip Code (actual location where services are provided to members)** Provider County Provider Telephone Number Type of Provider as defined under Rhode Island Regulation 230-RICR-20-30-9.3 (23) Provider Specialty Provider Credentials/Licenses Handicap/Special Needs Accessibility (Yes or No) Age range of patients treated Date provider joined the network (contract date) Termination Date, if applicable Current Network Status (In-Network or Out-Of-Network) Network Tier, If applicable

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<p>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</p> <p>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.</p> <p>r. Hospital admitting privileges (if applicable) or affiliation with in-network facilities</p> <p>s. Date of last filed claim for the provider</p> <p>*Please label the Excel file with the corresponding network name.</p> <p>**If the provider has more than one location in which services are provided, please include a separate line of data that is applicable to each location.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>
4.1	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4.2	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4.3	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4 – A.1	February 14, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4 – A.2	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.
4 – A.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.
4 – A.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.
4 – A.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.
4.4	August 17, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
4.5	August 28, 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.
4.6	October 1, 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.
4.7	October 1, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

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

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
5.6	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
5.7	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
6	October 11, 2019	<p>Please provide the following information.</p> <ul style="list-style-type: none"> a. The policies and procedures used for updating the provider directory. b. Information provided to providers, including contact number and/or website to update provider contact information or status in the plan network. c. Internal timeline to complete provider directory update requests. d. Process for updating beneficiaries' access to updated provider directory information. e. The procedures for making provider directories available to beneficiaries, providers and the public. This information should include the formats available (print or electronic) and measures taken to accommodate individuals with limited English proficiency and/or disabilities. f. Process and method to inform and assist beneficiaries on how to choose and/or utilize a network plan, select or change a provider, access an updated provider directory in each network plan, and inform the members on the use of tiered networks within a network plan to include changes in beneficiaries' financial liability. Also, provide the dedicated line and telephone number that beneficiaries must call to request assistance with finding care and an available provider. <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding</p>

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		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 5, 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	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
7	October 11, 2019	<p>Please provide the policies, procedures and controls for validating the information contained in the Provider Directory. Please include a summary explanation and details regarding the quality assurance program and quality reviews (QR's) performed prior to finalizing the Provider Directory.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p>
7.1	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
8	October 11, 2019	Please provide a list of all internal audits, internal compliance reviews and external audits conducted regarding provider directory accuracy and ensuring compliance with Rhode Island state regulations and statutes. For each, include a summary of the scope and indicate whether any issues were identified and/or corrective actions taken.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		The Period that applies to this request is January 1, 2019 through August 31, 2019. Please provide the most recent internal audits, internal compliance reviews and external audits conducted. If such reviews were not performed during the Period, please provide your most recent audits.
8.1	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
8.2	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
8.3	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
8.4	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
8.5	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
8.6	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
8.7	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
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.
9.1	December 5, 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	October 28, 2019	Provide the Company's complaints and grievances logs maintained during the Period. The log or report should contain the following information: <ul style="list-style-type: none"> a. Policy number b. Network ID c. Source of complaint/grievance review request (beneficiary, provider, OHIC, claimant's attorney, etc.) d. Type of coverage (medical, mental health, etc.) e. Type of complaint/grievance (adequacy of network, provider directory error, etc.) f. Company identification number/code for the complaint/grievance g. Reason for complaint/grievance h. Date request received i. Date resolved j. Outcome <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>
10.1	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
10.2	December 5, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
10.3	January 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.
10.4	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
Network Adequacy Requests		
11	October 11, 2019	<p>Please provide the policies, procedures, criteria, and selection standards used regarding the admission of providers to the Company's network. Also, include specific information regarding each type of provider and specialty such as medical, surgical, mental health and substance use providers.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p> <p>Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>
11.1	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
11.2	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
12	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

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<p>each of its network plans (and network tiers, if applicable) are <u>sufficient in scope and in volume</u> to assure the network will:</p> <p>Address and monitor its population needs that all covered services for beneficiaries, including children, adults and low-income, medically underserved beneficiaries, children and adults with serious chronic and/or complex health conditions or physical and/or mental disabilities and persons with limited English proficiency, are accessible in a timely manner without unreasonable delay.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p> <p>Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>
13	October 11, 2019	<p>Answer separately for each network (and network tier, if applicable):</p> <ol style="list-style-type: none"> Is the network open to any willing provider or does the network remain closed unless a specific need or gap is identified? Describe the methodology and provide supporting documentation. Does the Company's policy for maintaining an open or closed network admission process differ for certain specialties of providers based on gaps of coverage, shortages, areas of need, or quality of services, etc.? Describe the process and provide supporting documentation. Please indicate if the network will deviate in any way for 2020. If changes to the network will occur, please provide a detailed summary of such changes. Finally, please indicate if the network will terminate after December 31, 2019. In reference to all new networks that will be introduced during 2020, please provide a response to inquiries a. and b. above.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		The Period that applies to this request is January 1, 2019 through August 31, 2019 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	<p>Please provide the policies, procedures and protocols for evaluating the adequacy of the Company's network of providers.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p> <p>Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>
14.1	December 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	<p>How frequently does the Company monitor the adequacy of providers for each network plan? Please provide documentation that supports the Company's compliance with 230-RICR-20-30-9.6(E) and 230-RICR-20-30-9.7(B).</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p>

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

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
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.
16.2	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.
16.3	December 31, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
17	October 28, 2019	<p>For each network separately (and network tier, if applicable), please provide an <i>Excel</i> document listing of all paid and zero paid (approved) claims (final adjudication), both in-network and out-of-network from September 1, 2017 through August 31, 2019 for policies/certificates issued in Rhode Island. The file(s) should include the following data fields:</p> <ol style="list-style-type: none"> Policy number Type of policy (individual, small group or large group and definition of each) Claim number Product/plan name Network ID Network tier, if applicable Date of service Date received Claim amount Allowable amount Paid amount Cost sharing amount applied (dollar amount beneficiary was responsible for) Provider Name National Provider Identifier (NPI) Network status (in or out-of-network) Actual provider address where the services were provided

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<p>q. Type of service (emergency, inpatient, outpatient, partial hospitalization, residential treatment facility, office visit, etc.)</p> <p>r. Primary diagnosis code</p> <p>s. Secondary diagnosis code</p> <p>t. Tertiary diagnosis code</p> <p>u. All other available diagnosis codes in the system associated with the line item</p> <p>v. Procedure/Revenue code</p> <p>w. Remark Code</p> <p>x. Indicator for manual or auto adjudication</p> <p>y. Date approved</p> <p>z. Date paid</p> <p>Please provide a data dictionary or legend that defines the Company's column headings and acronyms that may be used in the requested data. Also, provide a listing of all remark codes and their definitions.</p> <p>The Period that applies to this request is September 1, 2017 through August 31, 2019.</p>
17 – B.1	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.
17.1	July 22, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
17.2	July 22, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
17.3	July 22, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
17.4	August 3, 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.
17.5	August 3, 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.
17.6	August 3, 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.
17.7	August 17, 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.
17.8	August 28, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
18	October 28, 2019	<p>For each network separately, as applicable, please provide an <i>Excel</i> document listing of all denied claims (final adjudication), both in-network and out-of-network from September 1, 2017 through August 31, 2019 for policies/certificates issued in Rhode Island. The file(s) should include the following data fields:</p> <ul style="list-style-type: none"> a. Policy number b. Type of policy (individual, small group or large group and definition of each) c. Claim number d. Product/plan name e. Network ID f. Network tier, if applicable g. Date of service h. Date received i. Claim amount

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<ul style="list-style-type: none"> j. Allowable amount k. Provider Name l. NPI m. Actual provider address where services were provided n. Network status (in or out-of-network) o. Type of service (emergency, inpatient, outpatient, partial hospitalization, residential treatment facility, office visit, etc.) p. Primary diagnosis code q. Secondary diagnosis code r. Tertiary diagnosis code s. All other available diagnosis codes in the system associated with the line item t. Procedure/Revenue code u. Indicator for manual or auto adjudication v. Denial code w. Denial reason x. Date denied y. Date explanation of benefits mailed <p>Please provide a data dictionary or legend that defines the Company's column headings and acronyms that may be used in the requested data. Also, provide a listing of all denial codes and their definitions.</p> <p>The Period that applies to this request is September 1, 2017 through August 31, 2019.</p>
18 - B.1	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.
18.1	July 22, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
18.2	July 22, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
18.3	July 22, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
18.4	August 3, 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.
18.5	August 3, 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.
18.6	August 3, 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.
18.7	August 17, 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.
18.8	August 28, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
19	October 11, 2019	<p>For each network (and network tier, if applicable) separately, please define "excessive waiting time for an appointment". If this definition varies by type of provider and/or the type of service requested (periodic physical examination, diagnosis to treat severe symptoms, etc.), please include detailed information that applies to each provider and/or type of service.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated</p>

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		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	<p>For each network (and network tier, if applicable) separately, please provide an <u>Excel listing</u> of all out-of-network (all health plans such as HMO, PPO, etc.) exception requests and decisions (where gaps in networks were identified, provider wait time for an appointment was excessive, etc.) made by beneficiaries or providers during the Period, which should include the following data fields:</p> <ul style="list-style-type: none"> a. Product/Plan name b. Reason for request c. Outcome (approved or denied) d. Percent of coverage (e.g., 100%, 50%, 0%, etc.) e. Service or procedural code requested f. Specialty of Provider requested g. NPI h. Provider address including zip code i. Provider county <p>Please provide a data dictionary or legend that defines the Company's column headings and acronyms that may be used in the requested data.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>
20.1	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.2	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.3	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.4	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.5	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.6	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.7	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.
20.8	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.9	February 21, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
20.10	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.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p> <p>If the information requested is expected to change during 2020, please provide a detailed summary of such changes. Finally, please provide this information for all new networks that will be introduced during 2020.</p>
21.1	December 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	October 11, 2019	<p>Please provide the credentialing/re-credentialing policies and procedures clearly indicating the requirements for each type of covered professional provider within the plan network(s). Include copies of application forms, as applicable.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, please supply any work flow charts regarding the processes noted above. If such work flow charts do not exist, please create them.</p> <p>Finally, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>
23	October 28, 2019	<p>For each network separately, as applicable, please provide an <u>Excel listing</u> of all professional provider credentialing or re-credentialing activities during the Period, which should include the following data fields:</p> <ul style="list-style-type: none"> a. Provider Name b. Reason for request (credentialing or re-credentialing) c. NPI d. Provider address including zip code

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		<ul style="list-style-type: none"> e. Provider county f. Receipt date of completed application or request g. Decision (approved or denied) h. Date of decision i. Date decision communicated to provider <p>The Period that applies to this request is January 1, 2019 through August 31, 2019.</p>
23.1	December 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.
23.2	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.
23.3	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.
23.4	December 31, 2019	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
24	October 11, 2019	<p>Please provide an electronic copy of the written standard defining what elements constitute a complete credentialing and re-credentialing application. Please also provide the website address where this standard may be located.</p> <p>The Period that applies to this request is January 1, 2019 through August 31, 2019. If the information requested above was updated during the Period, please provide a tracked changes version of the edited documents. Also, if the information requested is expected to change during 2020, please provide a detailed summary of such changes.</p>

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
25	December 31, 2019	<p>230-RICR-20-30-9.5 provides, a health care entity must maintain regular and meaningful oversight of each of its delegates to ensure every such delegate is in compliance with the Act's network plan requirements. In addition, it also provides, for any portion of the health care entity's network plan activity that is delegated, the health care entity shall be responsible for oversight and be held accountable for all activity delegated and for any non-compliance of its delegate with the Act. The examiners were notified that the Company delegated some plan requirements to Optum Behavioral Health ("Optum").</p> <p>Please provide the following documents and/or additional information:</p> <ol style="list-style-type: none"> 1. Copy of the delegation agreement entered into between the Company and Optum. 2. Please explain how the Company ensures through supervision and monitoring controls that Optum is performing the delegated functions in accordance with the agreement for network adequacy and the provider directory. 3. Copies of all quarterly Network Adequacy Geo-Access reports and other network adequacy documentation provided by Optum to the Company during the exam Period. If no reports were provided, did the Company require the quarterly reports as part of its oversight responsibility? If the Company did not require the quarterly reports, please explain. 4. A listing of all provider directory related reports provided by Optum to the Company that allows UHIC/UHCNE to review and ensure the complete and accurate processing of updates (new providers, changes to provider information) to the provider directory. Please indicate the frequency of such reports, the individuals responsible for reviewing the information and the process for addressing identified issues (untimely transactions, high error rates, etc.) Please provide an example of each report. If the Company did not require any reports from Optum, please explain. 5. A listing of reviews performed by UHIC/UHCNE to ensure that provider directory and network adequacy functions delegated to Optum are being processed in accordance with Rhode Island requirements and

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
26	December 31, 2019	the provisions as stated in the delegation agreement. If the company did not perform any reviews, please explain.
		6. A listing of all network adequacy and provider directory quality review reports provided by Optum to the Company during the exam Period. Please explain how the Company used these reports to improve the quality of services provided by Optum. Please provide an example of each report. If the company did not require any reports from Optum, please explain.
		The following requests pertain to information discussed during the Optum provider directory and network adequacy interviews conducted by RRC on December 17, 2019. Please provide the following:
		1. The reports from Optum to the Company regarding Single Case Agreements with out-of-network providers for the Period.
		2. The quarterly business review reports, agendas, meeting minutes or other documentation related to updates regarding provider directory, network adequacy and provider credentialing activities provided by Optum to the Company during the Period.
		3. The script that is utilized to conduct the secret shopper review.
		4. During the interview, Optum noted that claims for a terminated provider would be processed at the in-network benefit level for 90 days following the termination date. Please provide the policy and procedures in effect during the Period that support the statement noted above.
		EXAMINER NOTE: It is important to note that the BH Delegate's (Optum) response to this request retracted the 90 day timeline as noted above. The Company provided the following response (Confidential): The Company's response did not explain why the above referenced document titled RI Member Notification of Provider Termination Addendum was not provided in response to initial data requests regarding the Company's compliance with 230-RICR-20-30-9.9 (A) (2) (a). Also, the Company did not explain why their delegated entity, Optum, was unaware of this RI Addendum during the interview that was conducted on December 17, 2020.

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
27	February 21, 2020	During the interview with the Company on January 9, 2020, the Company stated that weekly monitoring of network adequacy is performed by internal Company employees. 27. a) Please provide the policy that supports the Company's comments that weekly monitoring of network adequacy is performed by employees. 27. b) Please provide copies of all weekly network adequacy reports performed during the Period.
28	February 21, 2020	During the interview with the Company on January 9, 2020, the Company stated that Quest Analytics performs weekly network adequacy testing on the plans' networks of providers. Please provide copies of all the reports that were generated during the Period by Quest Analytics and provided to the Company. 28.a) Please provide the Company's policy regarding the oversight and quality review checks performed on the reports generated by the third party vendor Quest Analytics. If an internal Company policy addressing this does not currently exist, please provide a written response of any quality reviews performed by the Company relative to the reports generated by the third party vendor Quest Analytics, including any quality control measures such as accuracy or validation checks against sources of truth, etc. Provide a copy of the delegation agreement entered into between the Company and Quest Analytics. Please explain how the Company ensures through supervision and monitoring controls that Quest Analytics is performing the delegated functions in accordance with the agreement for network adequacy.
29	February 21, 2020	During the interview with the Company on January 9, 2020, the Company stated that the network adequacy time, distance, and accessibility standards are tested for 55 specialty groupings (i.e., different types of providers). The Company then indicated that only 33 of those specialty groupings are required to be tested under the Company's policy. Please provide a complete list of the 55 specialty groupings that are tested based on the Company's network adequacy time, distance, and accessibility standards. For each of those 55 specialty groupings, define the credentials, licensure, degree, or other

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
		requirement to be included in that specialty grouping. Please provide a complete list of the 33 specialty groupings that the Company referenced as being required to be tested based on the Company's network adequacy time, distance, and accessibility standards. Please provide the policy that addresses the 33 required specialty groupings that must be tested, including the basis of that requirement. Please provide a list of those 22 specialty groupings that are referenced as being informational.
30	February 21, 2020	During the interview with the Company on January 9, 2020, the Company stated for network adequacy and accessibility reporting by the Network Programs Division, Data Analytics Team, and the Network Accessibility and Adequacy Team, the Company is evaluating the networks that could be used but not necessarily the benefit design package or the product being sold. If a state such as RI has specific state mandated benefits that can only be provided by a certain type of provider or specialty, would that mandate be considered during the network adequacy and accessibility monitoring to ensure that the benefit is available from an in-network provider licensed and/or certified to offer that service? Explain how RI state mandated benefits are considered in the network adequacy and accessibility monitoring process. Provide any supporting policies relevant to items 30.a and 30.b.
31	February 21, 2020	During the interview with the Company on January 9, 2020, the Company stated for network adequacy and accessibility reporting by the Network Programs Division, Data Analytics Team, and the Network Accessibility and Adequacy Team, the Company is not evaluating appointment wait times. Who is responsible at the Company for reviewing appointment wait times? [Include business unit, number of employees, etc.] Please provide the supporting policy and/or other process documents utilized to perform the review of appointment wait times. Applicable to the products and networks under review (RI-situated commercial plans), please provide all monitoring reports, audit results, or other assessments performed during the Period testing appointment wait times.
		Other Miscellaneous Requests Submitted by Email

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IDR #	Due Date – as soon as possible but no later than the date noted within each request	Description
NA	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.
NA	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.
NA	December 4, 2020	Supplemental IDRs are deemed confidential because of confidential information included in the follow up question and it was determined that the confidential information could not consistently and reasonably be segregated from the supplemental IDRs in a meaningful way.
NA	January 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.
NA	September 11, 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.
NA	October 15, 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.
NA	October 15, 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.

Appendix B

Claims Data Analysis

I. Introduction:

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

II. Methodology to Analyze Claims Identified by Procedure Code:

A. Initial Procedure Code Filters.

On 7/22/20 UnitedHealthcare Insurance Company and UnitedHealthcare of New England, Inc. ("United") submitted its sixth set of claims data as the Examiners found the first five sets to be inaccurate and/or omitted key data. This claims data included a field labeled "Parstat" that indicated whether or not that claim was from an in-network (INN) provider that participated in United's network at the time of the claim. In response to a September 30th, 2020 Examiner request for additional information to IDR 4 in order to conduct a quality check on the sixth version of United's IDR 17 and 18 claims set, United submitted participating provider data for

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Massachusetts. Resubmitted IDR4 provider network data for Massachusetts providers was combined with previously submitted Rhode Island providers network data and merged by NPI to Rhode Island and Massachusetts claims. This NPI-based network status was then compared to the network status defined by the Parstat field in the claims data. Of the 892,052 Rhode Island and Massachusetts claims, 106,424 (11.9%) that were categorized as INN in the Parstat field did not have matching NPIs in the combined Rhode Island and Massachusetts IDR4 submissions. This INN status discrepancy most likely indicates that incomplete IDR4 provider data was submitted. Thus the Examiners concluded that the sixth submitted version of IDR 17 and 18 was more reliable claims data as it was retrieved by United from a centralized data base.

From this sixth version of four Excel spreadsheets (segmented by paid or denied and UHIC vs. UHCNE), the Examiners selected claims for services rendered during the Exam Period September 1, 2017 through August 31, 2019. These spreadsheets were consolidated into a unified data model in Microsoft Power BI, which collated 1,326,145 claims. 674,583 claims with procedure codes 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:

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- 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 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 238,468 procedure code claims were analyzed as noted below.

B. Procedure Codes Analyzed

From the remaining 238,468 procedure coded claims, as shown in UHC Procedure Code Table 1 Tab 2 No Dx, the Examiners removed procedure codes that had a similar service category to those service category codes already excluded via the process noted in Section II A above. UHC Procedure Code Table 1 No Dx, Tab 3 identifies the remaining 202,892 professional procedure claims, which were then analyzed by the Examiners to assess network inadequacies, as presented in the market conduct examination main report ("MCE"). The Examiners then reviewed the claims analyzed in UHC Procedure Code Table 1 No Dx Tab 3 to identify related diagnoses. UHC Procedure Code Table 2 With Dx, Tab 1 shows diagnoses with at least 6 OON claims representing 129,061 claims. These claims were further analyzed as shown on UHC Procedure Code Table 2 With Dx Tab 2 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.

United submitted four Excel spreadsheets for the Data Period referenced above, segmented on these excel spreadsheets by paid or denied, as well as UHIC vs. UHCNE. These were consolidated into a unified data model in Microsoft Power BI, which resulted in 1,326,145 claims. The Examiners then selected only the claims

with a valid Revenue Code which resulted in 161,271 claims. The Examiners then applied an additional filter to include only those claims with Revenue Codes where at least 25 claims were out-of-network, which resulted in 99,696 claims.

B. Revenue Codes Analyzed.

The Examiners analyzed the 99,696 claims, as shown on UHC Revenue Code Table 1 No Dx Tab 3 and removed the claims with revenue codes similar to the service categories excluded in Section II A above. UHC Revenue Code Table 1 No Dx, Tab 4 presents the resulting 31,589 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 UHC Revenue Code Table 1 With Dx identifying related diagnoses and applying a filter to require at least one or more out-of-network claim as seen on UHC Revenue Code Table 2 with Dx, Tab 1. The Examiners then applied an additional filter to these 8,256 claims on UHC Revenue Code Table 2 Tab 1 identifying only those claims by diagnosis with at least six (6) OON claims (UHC Revenue Code Table 2 with Dx Tab 2). These Table 2 claims totaling 4,357 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.

Appendix E

OHIC Complaint Identifications Document

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

Appendix F

Instructions for Attestation of ACCURACY and COMPLETENESS

The Rhode Island Office of the Health Insurance Commissioner (OHIC) is conducting a market conduct examination (the Examination) of UnitedHealthcare Insurance Company and UnitedHealthcare of New England (collectively referred to as United), which includes a review of United's mental health and substance use disorder and medical and surgical claims adjudicated by United during the period of the Examination, which is September 1, 2017 through August 31, 2019 (the Period).

The purpose of this form is to facilitate having United's Chief Financial Officer (CFO), Chief Claims Officer (CCO) or Chief Operating Officer (COO) attest that United's claims data provided to OHIC in response to Information Data Requests (IDR) 17 and 18, are complete and accurate (within an immaterial range of variance). The form also serves to confirm that the claims data reconciliation provided to the Examiners in response to IDRs 17.3 and 18.3 was prepared by reconciling United's source claims against financial systems for claims adjudicated during the Period. This form will also serve to certify that United has provided OHIC with the requested claims data and file documentation consistent with the instructions provided by OHIC and that such data and information provided to OHIC is accurate and complete.

The attestation should be made after United's CFO, CCO or COO has reviewed and considered all relevant information, including in particular, the claims data provided to OHIC in response to the above referenced IDRs 17 and 18, including written and/or documented representations made by United employees, as being accurate and complete.

If United's CFO, CCO or COO are unable to attest to the accuracy and completeness of the claims data United provided to OHIC in response to IDRs 17 and 18, please advise OHIC immediately and submit:

- A written explanation for this lack of accuracy and completeness within 5 business days of receipt of this attestation request; and

If a sampling of the above received claims data, which has been certified to be complete and accurate by United, is determined to be inaccurate or incomplete, United shall, at a minimum, bear any cost associated with the re-performance of the subject examination work.

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ATTESTATION of Accuracy and Completeness

This form must be completed and signed by United's CFO, CCO or COO

A. Responsible Officer

Name: (Last) _____ (First) _____ (MI) _____

Title: _____

Street or P.O. Box: _____

City/State/Zip Code: _____

B. Attestation of Accuracy and Completeness (to be signed by United's CFO, CCO or COO)

I certify under penalty of law, based upon the information and belief formed after reasonable inquiry and review, the statements and information contained in these documents are true, accurate and complete to the best of my knowledge and belief.

Name: (Signed) _____

Name: (typed) _____ Date: _____

Subscribed and sworn to before me on the ____ day of _____, 2020

Notary Public
My Commission Expires: _____

In re Examination of Health Insurance Carrier Compliance with Network Adequacy
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Appendix G

United Attestation of Accuracy and Completeness

ATTESTATION of Accuracy and Completeness

I, Kevin M. Ericson, Vice President, Regulatory Financial Operations for UnitedHealthcare, attest that, to the best of my knowledge and belief, formed after reasonable inquiry and review, the claim data provided on July 22, 2020, to the Rhode Island Office of the Health Insurance Commissioner (OHIC) and Risk and Regulatory Consulting (RRC), as part of the Market Conduct Exam initiated by OHIC on September 27, 2019 is accurate and complete.

Kevin M. Ericson

Kevin M. Ericson
Vice President, Regulatory Financial Operations
UnitedHealthcare

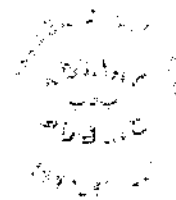
9/25/20

Date

Tanveer Chowdhury

Commission Expires: Aug 31, 2021

Tanveer Chowdhury



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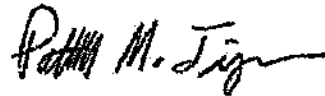
Wherefore, it is hereby ORDERED:

- A. The Commissioner hereby adopts the Examination Report and Recommendations.
- B. United shall report to the Commissioner on January 31, 2023 regarding the implementation of all recommendations in this report.
- C. United shall provide a compliance audit and other such information as reasonably requested by the Commissioner.
- D. In lieu of a penalty, United shall make a financial contribution to the Rhode Island Foundation (RIF) in the total amount of \$275,000.00. The contribution dollars shall be used to support the Rhode Island doula workforce community in the areas of workforce development and training. It is the Commissioner's expectation that the \$275,000.00 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 United's cost of implementing this Report's Recommendations and Orders.
- E. Within 30 days of the issuance of this Order, United shall file with the Commissioner affidavits executed by each Director of United 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

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

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



Patrick Tighe, Commissioner

**THIS ORDER CONSTITUTES A FINAL ADMINISTRATIVE DECISION OF THE
OFFICE OF THE HEALTH INSURANCE COMMISSIONER. AS SUCH, THIS ORDER
MAY BE APPEALED PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT,
CHAPTER 36 OF TITLE 42 WITHIN THIRTY (30) DAYS OF THE DATE OF THIS
ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION
FOR REVIEW IN SAID COURT.**

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Consent of UnitedHealthcare Insurance Company and UnitedHealthcare of New England, Inc.

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

By:  Date: 2/1/22

Title: CEO, Northeast Region

By:  Date: 2/17/22

Title: CEO, Employer & Individual



December 22, 2021

Mr. Patrick M. Tighe
Health Insurance Commissioner
Rhode Island Office of the Health Insurance Commissioner
1511 Pontiac Avenue Bldg. #69
Cranston, RI 02920

Re: UnitedHealthcare Insurance Company and UnitedHealthcare of New England Market
Conduct Report on Network Adequacy and Provider Directory

Dear Commissioner Tighe:

I am writing in response to the above referenced exam report issued by the Office of the Health Insurance Commissioner ("OHIC"). UnitedHealthcare Insurance Company and UnitedHealthcare of New England (collectively "United") would first like to thank the Commissioner for allowing us the opportunity to submit this letter in response to the examination report. United's goal is and always will be the safety and well-being of its Rhode Island members. In that same spirit United takes very seriously, the findings included in the report. Although there are points within the report where United and OHIC disagree, United is committed to improve processes, if it has not done so already.

With regard to the "Complaint Findings and Conclusion" section, we note that United and United Behavioral Health ("Optum") have made significant improvements to our process. And due to feedback received from OHIC during the most recent annual complaint report submission in 2020, United undertook a project to revamp the complaint reporting process in its entirety. We believe these improvements will remediate the concerns within the report.

Regarding the "Provider Directory" section of the report, United and Optum maintain numerous processes for maintaining accurate provider directories. And although United and OHIC may have disagreements pertaining to the directory findings, United is looking ahead with the intent to take positive steps to only improve its provider directory and the data within, ultimately improving the member experience.

Regarding the "Network Adequacy" section of the report, even as United respectfully disagrees that its networks "may be" inadequate, United will take this opportunity to act upon OHIC's recommendations in order to provide Rhode Island members access to a top-notch network that is easily accessible to meet their medical needs.

Finally, regarding United's obligation to facilitate the exam, we are disappointed by the examiner's conclusions. With that said, we are always seeking opportunities for improvement. We take the report comments with all seriousness and are committed to strengthening our processes as recommended in the report.

Thank you again for the opportunity to submit this letter in response to the exam report. We are proud of the improvements we have made so far as result of this exam and will continue to improve based on OHIC's recommendations. We look forward to our continuing partnership with OHIC ensuring superior care to our Rhode Island members.

Sincerely,

A handwritten signature in cursive script, reading "J. Stangl".

Joseph Stangl
Director, Regulatory Affairs
UnitedHealthcare
4 Research Drive
Shelton, CT 06484
203-447-4474
Joseph_stangl@uhc.com