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

In Re:	Examination of Health Insurance Carrier Compliance With Mental Health and Substance Abuse Laws and Regulations	)))	OHIC-2014-3

Examination Report of Tufts Insurance Company and Tufts Associated Health Maintenance Organization, in accordance with R.I.G.L. § 27-13.1-5(b).

In re Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3

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February 12, 2020

Honorable Marie Ganim
Health Insurance Commissioner
State of Rhode Island

Dear Commissioner Ganim:

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 mental health and substance abuse by all four major health insurance carriers in Rhode Island. This Examination Report addresses compliance by Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively "THP"). Other Examination Reports address compliance by the other carriers.

The examination was conducted by Linda Johnson, former OHIC Operations Director (as of October 15, 2019, OHIC Independent Contractor), and Herbert W. Olson, Esq. (former OHIC General Counsel), with the assistance of OHIC and EOHHS staff, and with clinical expertise from behavioral health clinicians associated with the Law and Psychiatry Service at Massachusetts General Hospital. In conducting the examination, the Examiners observed those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners, together with other appropriate guidelines and procedures as the Commissioner deemed appropriate.

Linda Johnson, (Contractor, Former Operations Director)
RI Office of the Health Insurance Commissioner

Herbert W. Olson, Esq.
Hillsboro Mountain PLC

ROSANNE PASQUALE
MY COMMISSION EXPIRES
APRIL
09,
2021
STATE OF RHODE ISLAND
NOTARY PUBLIC

On this 10th day of February, 2020, before me, the undersigned notary public, personally appeared Linda Johnson, 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 18 day of Feb, 2020, before me, the undersigned notary public, personally appeared Herbert W. Olson, 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

CHERYL ESTEY
NOTARY PUBLIC
COMMISSION NO. 157006
STATE OF VERMONT

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 ("OHIC") on January 8, 2015. The Commissioner appointed as Examiners (among others) Linda Johnson, former OHIC Operations Director, and Herbert W. Olson, Esquire (former OHIC General Counsel). The Examination is a targeted examination of the four largest health insurance carriers in the Rhode Island insured market: Blue Cross Blue Shield of Rhode Island ("Blue Cross"), Neighborhood Health Plan of RI ("Neighborhood"), Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively "THP"), UnitedHealthcare Insurance Company, and UnitedHealthcare of New England, Inc. (collectively "United RI") (collectively "the Carriers").

The purpose of the Examination is to review compliance by the Carriers with federal and state laws and regulations relating to health insurance coverage of mental health and substance use disorder benefits (collectively, mental health and substance use are referred to in this Report as "behavioral health" or "BH").

This Examination Report addresses compliance by THP. Other Examination Reports have or will address compliance by the other Carriers.

The Examination targeted two broad areas of regulatory compliance: first, compliance with federal and state behavioral health parity laws and regulations. The second targeted area of regulatory compliance for the Examination has been carrier compliance with state and federal requirements relating to utilization review policies, procedures, and their implementation.

The Examination initially targeted Carrier records and operations during the 2014 calendar year period. For THP's Examination, however, records and operations during the 2014 and 2015 calendar years were targeted, because two years of records were needed to achieve a sufficient number of cases to review.

Initial requests for information were submitted to the Carriers in September 2015. The Examination was suspended in June 2016 following adjournment of the Rhode Island Legislature, and was re-commenced in December 2016.

2. Applicable statutes and regulations

   a. Carriers must use clinically appropriate utilization review criteria. Carriers are obligated to provide coverage for members with behavioral health conditions by virtue of their obligation to comply with their approved health benefit plan forms. RIGL §§ 27-18-8, 27-19-7.2, 27-20-6.2, and 27-41-29.2. The approved health benefit plans of THP promise to cover behavioral health services, including a continuum of care for members with mental health and substance abuse conditions. Carriers are also obligated to provide coverage for members with behavioral health conditions by virtue of RIGL § 27-38.2-1(a), which includes both an obligation to provide coverage for the treatment of mental health and substance use conditions and disorders defined and identified in the Diagnostic and Statistical Manual of Mental Disorders, as well as an obligation that coverage be provided under the same terms and conditions as coverage is provided for medical and surgical conditions. Typical "terms and conditions" of coverage include the utilization review process.

      The utilization review process can be a legitimate affordability mechanism designed to allocate finite insurance carrier premium revenue in a cost-effective manner, for the benefit of all consumers; however, when utilization review procedures are applied to potentially limit the underlying obligation to provide behavioral health coverage, the utilization review process must be fair and equitable, and must be applied in accordance with reasonable standards. RIGL § 27-9.1-4(a)(3) and (4) (Unfair Claims Settlement Practices Act). In order to fulfill those obligations, the Carrier must use clinically appropriate criteria when making its utilization review determinations. If inappropriate clinical criteria were used, the utilization review process would be neither fair nor equitable and would not use reasonable standards in making claims determinations. Instead, the Carrier would be acting in an arbitrary manner to deny coverage for behavioral health services that are otherwise required by law to be covered.

      The Title 27 obligation to use clinically appropriate utilization review criteria is consistent with RI Department of Health Regulation R23-17.12 (DOH Utilization Review Regulation) § 3.2.20, which requires utilization review agents to use "written medically acceptable screening criteria." Thus, the obligation to use

clinically appropriate criteria in determining whether to approve or deny behavioral health services is independently grounded in both Title 27, RIGL, and in the DOH Utilization Review Regulation. Since the commencement of this Examination, authority for enforcement of these Department of Health Regulations has been transferred to the Office of the Health Insurance Commissioner.

b. Carriers must apply their utilization review criteria in a clinically appropriate manner. Carriers are also obligated to apply utilization review criteria in a clinically appropriate manner. If criteria are not applied in a clinically appropriate manner, the utilization review process would be neither fair nor equitable, nor use reasonable standards and procedures in making utilization review decisions. Unfair Claims Settlement Practices Act. The obligation to apply utilization review criteria in a clinically appropriate manner is consistent with the legal obligation under the DOH Utilization Review Regulation to use and apply utilization review criteria and procedures in a clinically appropriate manner. DOH Utilization Review Regulation § 3.2.20. Thus, the obligation to apply clinically appropriate criteria in determining whether to approve or deny behavioral health services is independently grounded both in Title 27, RIGL, and in the DOH Utilization Review Regulation.

c. Carriers must adopt and implement reasonable utilization review standards and procedures, and must make prompt, fair and equitable utilization review decisions. Health insurance companies are subject to the Unfair Claims Settlement Practices Act. The Act in particular prohibits "[f]ailing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies." RIGL § 27-9.1-4(a)(3). The Act also prohibits "[n]ot attempting in good faith to effectuate prompt, fair, and equitable settlement of [valid] claims". RIGL § 27-9.1-4(a)(4). Together, the Act as applied to the utilization review process requires Carriers to establish reasonable utilization review standards, and to act in a prompt, fair, and equitable manner in reviewing requests for approval of coverage for behavioral health services. The DOH Utilization Review Regulation and the RI Department of Health Regulation R23-17.13 (DOH Health Plan Certification Regulation) prohibits many practices which

also constitute violations of the Unfair Claims Settlement Practices Act. Thus, Carriers' obligation to establish reasonable utilization review standards, and to act in a prompt, fair, and equitable manner in acting upon requests for approval of coverage for behavioral health services is independently grounded in both Title 27, RIGL, and in RI Department of Health Regulations.

d. Carriers must provide coverage of benefits and services without unreasonable delay and without impeding care. A Carrier must provide coverage of benefits described and promised in a member's health benefit plan. RIGL §§ 27-18-8, 27-19-7.2, 27-20-6.2, and 27-41-29.2. Coverage must be provided in a reasonably prompt manner. RIGL § 27-9.1-4(a)(3). The DOH Utilization Review Regulation and the DOH Health Plan Certification Regulation similarly prohibit many practices which would also constitute violations of Carriers' obligation to provide coverage of benefits and services without unreasonable delay and without impeding care. Thus, Carriers' obligation to cover services provided for in the member's health benefit plan without impeding care, and in a reasonably prompt manner is independently grounded in both Title 27, RIGL, and in RI Department of Health Regulations.

e. Carriers must maintain documentation of utilization review decisions sufficient to allow the Commissioner to determine compliance with legal obligations. A Carrier must provide documentation of its operations in a manner so that the Commissioner can readily ascertain the Carrier's compliance with RI insurance laws and regulations. RI Insurance Regulation 67, § 4.A ("Regulation 67"). In the case of health insurance companies, the obligation includes maintaining documentation of the practices of the Carrier regarding utilization review. Regulation 67 § 4.B. A health claims file must contain communications to and from members or their provider representatives, health facility pre-admission certification or utilization review documentation, any documented or recorded telephone communication relating to the handling of the claim, and any other documentation necessary to support claim handling activity. Regulation 67, § 6.A. Thus, the regulation makes clear that a Carrier's utilization review documentation must be sufficient to demonstrate to the Commissioner during a market conduct examination that the Carrier is in compliance with state insurance

laws, including laws and regulations within Title 27, and health insurance laws and regulations authorized under Title 23.

f. Mental health and substance use disorder coverage must be provided at parity with medical-surgical coverage. State law requires parity in coverage for mental health and substance use conditions with medical-surgical conditions. Rhode Island's parity law was originally enacted in 1994 and amended in 2014 to reflect the federal behavioral health parity law enacted in 2008, and to reflect final federal regulations adopted in 2013. The core legal principals and parity obligations for carriers have remained the same throughout the examination 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 coverage is provided for other illnesses and diseases. RIGL § 27-38.2-1(a).

Federal law also requires parity in coverage for mental health and substance abuse conditions with medical-surgical conditions. Among other requirements, federal law prohibits the application of non-quantitative treatment limitations unless the behavioral health limitation is comparable to, and no more stringently applied than the treatment limitation applicable to medical-surgical treatment. 42 U.S.C. § 300gg-26.

Federal regulation further requires coverage of medically necessary behavioral health services in the individual and small group markets. 45 C.F.R. § 156.110(a)(5).

Utilization review standards and procedures are considered "non-quantitative treatment limitations" ("NQTL's") which may not be imposed on coverage of behavioral health services unless the behavioral health utilization review standards and procedures, and the manner in which they are developed, are comparable to, and applied no more stringently than utilization review standards and procedures applied to medical-surgical benefits and coverage. RIGL § 27-38.2-1(d). 45 C.F.R. § 146.136(c)(4). Utilization review programs administered for behavioral health services are not "comparable to" medical-surgical services: (i) if prior authorization is required or recommended in a more pervasive manner for behavioral health services as compared to the scope of medical-surgical

services for which prior authorization is required or recommended, (ii) if prior authorization is required or recommended for a medically necessary continuum of care for chronic behavioral health conditions, but is not comparably required or recommended for chronic medical conditions, (iii) if prior authorization is applied in a more stringent manner to behavioral health conditions than for medical-surgical conditions, or (iv) if benefit plan exclusions apply exclusively to behavioral health conditions or services. 45 C.R.F. § 146.136(c)(4) (examples 9 and 10). While federal parity regulations changed in some respects between the Interim Final Regulations adopted in 2010 and the Final Regulations adopted in 2014, the provisions of the federal regulations applicable to this Examination and applied by the Examiners in their findings and conclusions of law in this Examination Report did not change between 2010 and 2014.

g. Other applicable statutes. RIGL §§ 27-13.1-1 et seq. (Examination Act).

3. Examination methodology and process.

a. The Commissioner initially appointed Linda Johnson, former OHIC Operations Director (Contractor), and Herbert W. Olson, Esq. (former OHIC General Counsel) as Examiners. Linda Johnson and Herbert Olson were in charge of the Examination. Assisting the Examiners were the following OHIC staff: Emily Maranjian, OHIC Legal Counsel, John Garrett, Principal Policy Associate, Cheryl Del Pico, Senior Policy Analyst, Victor Woods, Health Economics Specialist, Alyssa Metivier, Health Economics Specialist, Courtney Miner, Senior Policy Analyst, and James Lucht, RI EOHHS Deputy Director of Analytics.

b. The Examiners reviewed the policies and procedures of the Carriers related to utilization review and behavioral health parity, with an emphasis on policies and procedures already submitted to the RI Department of Health in connection with the Health Plan Certification and Utilization Review regulatory programs.

c. The Examiners requested and received from the Carriers case records of utilization review decisions (Case Records). Case Records are an important feature of the Examination, because they permit the Examiners to measure the actual implementation of a Carrier's policies and procedures against their legal obligations relating to utilization review and parity. The Examiners reviewed the Case Records for compliance with procedural or non-clinical requirements. The

Examiners also identified Case Records which needed review by behavioral health clinicians in order to evaluate the clinical appropriateness of Carrier utilization review criteria, utilization review decisions, and other matters requiring clinical judgment.

d. In accordance with the Examination Act, the Examiners retained expert clinicians in behavioral health associated with Massachusetts General Hospital (MGH Clinicians), under the direction of Ronald Schouten, MD, JD, Director, Law and Psychiatry Service. The Examiners identified the clinical issues to be reviewed by the MGH Clinicians and provided instructions for the review process. The Examiners' findings related to clinical issues are based in part on the clinical review of Case Records by the MGH Clinicians.

e. THP was cooperative and professional in terms of facilitating the Examiners' access to information needed to conduct the Examination.

Summary of Findings and Recommendations

Summary of behavioral health findings.

4. The Examiners reviewed all 103 Case Records provided and identified by THP as authorizations. The Examiners also reviewed all 16 Case Records provided and identified by THP as denials with 6 of those denial Case Records evidencing an appeal of the denial.

5. During the time periods examined, THP itself performed the utilization review function for behavioral health services delivered in its primary regional service territory. THP also delegated to Cigna, THP's third-party delegate, (hereafter, third-party delegate), the utilization review function for behavioral health services delivered outside its primary regional service territory. Notwithstanding such delegation, and notwithstanding third-party delegate's independent legal responsibilities under RI's Utilization Review Regulations and Network Plan Certification Regulations, THP is responsible for any failure of compliance by third-party delegate with RI state and federal health insurance laws and regulations.

6. It is the Examiners' observations that delegating the utilization review function to a third party presented challenges to THP in terms of overseeing the quality of the utilization review program and its impact on patients. When administering the utilization review program itself, THP's utilization review program appears to have fewer negative impacts on patients.

7. The Examiners find that the conduct, policies or procedures described in Paras. 8 through 13 constitute non-compliant practices under RIGL Title 27, Chapter 9.1, the DOH

Utilization Review Regulations, the DOH Health Plan Certification Regulations and/or Regulation 67. For the purposes of the findings and recommendations, references to THP shall be inclusive of third-party delegate(s), unless otherwise specified.

8. Clinically inappropriate utilization review criteria. The utilization review programs administered by THP and/or third-party delegate used clinically inappropriate utilization review criteria in some cases for coverage of behavioral health services. For example:

a. THP medical necessity standards, sometimes used in the process of conducting utilization review, are used in conjunction with other factors defined in THP health plans' certificates of coverage (see e.g., certificate of coverage (COC) for plan year 2014 page 134 & COC for plan year 2015 page 114). For example, some denial notifications included other qualifying conditions to the THP certificate of coverage definition of "medical necessity" that impacted the denial determination, such as the limitation that treatment and services will only be approved if they will improve the patient's condition.

b. Although its generalized medical necessity standard provides THP's utilization review reviewers with an opportunity to use their clinical judgment to over-ride the InterQual national criteria set used by THP, THP utilization review criteria did not provide for a reasonable process whereby clinically appropriate services can be approved for a patient even though the information presented does not fall within the four-corners of the national criteria set. For example, in one Case Record involving a retrospective medical necessity review, the patient with opioid addiction undergoing treatment in a detoxification facility needed continued stay in order to appropriately manage the patient's transition to medication assisted treatment. The patient would have been at risk of relapse and serious harm if the attending provider had discharged this patient too soon consistent with THP's decision, made on the patient's planned date of discharge, determining that the prior two days were not medically necessary. The retrospective review request for continued treatment and coverage was denied, in part, because the national criteria set required ongoing family/social support therapy, and this did not occur with this particular patient as there was no family or other support structure available to the patient (on or about page 9 of Case Record). The Examiners did

not find evidence of a formal policy that allowed for consideration of a particular patient's facts and circumstances.

c. The utilization review criteria used by third-party delegate have a number of defects, including:
    i. Denials can be based on subjective, generalized conclusions, rather than objective, clinically measurable criteria.
    ii. Treatment coverage can be denied because of past failures to succeed at treatment.
    iii. A patient can be denied treatment based on observations concerning functioning level in a structured environment that is not representative of the patient's functioning level outside of a structured environment.

9. THP and third-party delegate applied their respective utilization review criteria in a clinically inappropriate manner. For example:

a. In one Case Record, a patient with opioid addiction still in withdrawal was considered by THP to be not in withdrawal (page 46 of the Case Record COW=6) as of the day THP determined, retrospectively, the patient was appropriate for discharge. The MGH reviewer found that the patient's methadone dosing was still in flux and the patient had yet to be transitioned to Suboxone treatment when THP conducted its medical necessity review on the member's planned day of discharge. THP then determined that on the day of its review that that day forward and the previous two days were not medically necessary. Notable is that the patient had no family or other social supports adding to the risk of relapse if the patient had been discharged too soon. THP made these denial decisions in part because family/social support therapy was not taking place. See Paras 8(c), 10(a)(iii), 10(d)(i – ii) and10(f)(ii) for additional information.

b. In one Case Record, the third-party delegate denied partial hospitalization program coverage for a patient with opioid addiction. The third-party delegate erroneously found that the patient had a higher level of functioning that did not necessitate the partial hospitalization program. The third-party delegate also denied the treatment coverage request, in part, because the patient had not succeeded in treatment in the past (on or about page 33 of Case Record).

Patients should not be denied treatment because they present more difficult or more challenging treatment needs or they have been unable to improve or maintain a level of success given past treatments.

c. In another Case Record, the third-party delegate denied a request for treatment for a patient with opioid addiction, in part, because the patient had reached a "maximum benefit" (on or about pages 5 & 8 of Case Record) from all treatment, having failed in treatment in the past, and because the patient had not demonstrated to the third-party delegate's satisfaction a willingness to address the reasons for past treatment failures. The "maximum benefit" standard should not be a reason to deny medically necessary care. Also, a patient who self presents for treatment in actuality shows a willingness to participate in treatment.

10. Other inadequate utilization review practices.

a. Notice of adverse benefit determination - principal reason for denial.

i. THP did not fully and properly state the principal reason for denial in its adverse benefit determination notices.

ii. For example, in one Case Record THP denied a request for residential treatment for a patient with alcohol use disorder. The denial notification documents that the determination was based, in part, on findings that the patient's living environment was safe, the patient had family support, and the patient was medically and psychiatrically stable. The denial further states that THP used a subset of InterQual level of care guidelines to evaluate medical necessity; however, the notification letter did not direct the patient or provider to all the specific elements of the guideline subset applicable to this patient's coverage given the entirety of the clinical circumstances of the patient. Directing the patient and attending provider to the national criteria subset (13 pages of clinical criteria) is not adequate for the patient or attending provider to effectively appeal the denial decision and does not fully meet notification requirements.

iii. The Examiners identified four additional Case Records as examples of this practice.

b. Thorough and independent review.

i. Documentation practices suggest that the THP physician reviewers who denied coverage requests did not make a thorough and independent review of the case and, instead, suggest the physician reviewers simply concurred with the information and denial rationale of THP's case management staff.

ii. For example, in one Case Record, a THP case management staff noted observations concerning the patient's clinical condition that are essentially the same as the later documented observations of the physician reviewer in making the utilization review decision. Based on the case documentation submitted by THP, the Examiners were unable to clearly substantiate a separate review of the clinical circumstances of this patient nor an independent decision by the THP physician reviewer.

iii. The Examiners find that the absence of documentation to clearly substantiate an independent review is standard practice. The Examiners identified one additional Case Record as an example of this practice.

c. Denial and Appeal Processing.

i. There is no consistent clear documentation as to what was requested and what was approved contained in the Case Records, thereby the Case Records do not consistently and properly evidence when a denial was made, when an approval was made, or when an ordering provider may have modified a request. Inaccurate categorization of partial approvals/partial denials as approvals rather than denials impacts the ordering provider's and patient's opportunity to appeal. One Case Record appears to represent a patient for an admission to a hospital for inpatient mental health treatment for a psychotic disorder. THP was notified of the inpatient admission 36 days into treatment and conducted a retrospective review of 11 days (the patient was insured by another carrier for the first 25 days of the inpatient stay) for medical necessity and then reviewed this inpatient stay on a concurrent basis for an additional 50 days of coverage, after which a denial was issued for continued stay beyond that point. (See pages 4 & 5 of the Case Record). Pages 8, 13, 40, 42, 44, 46, 47-51, 53, 55, and 60 did not document the attending

provider's specific requests but did document what THP approved. This absence of documentation of the ordering provider's specific request is consistent throughout this Case Record. This practice of not clearly documenting an ordering provider's specific request was evidenced in a majority of both the authorization and denial cases.

d. Consideration of clinical information and the recommendations of the treating provider.

   i. THP did not adequately consider all of the clinical, treatment and family/social information concerning the patient. In one Case Record, a patient with opioid addiction who was still in withdrawal, as evidenced by clinical information contained in the Case Record (page 46 of the Case Record COWS=6), was considered by THP (in a retrospective coverage review) to not be in withdrawal. As noted in Para. 9, the patient's methadone dosing was still in flux on the days that THP determined were not medically necessary and the information in the Case Record indicated the patient had no family or other social supports, adding to the risk of relapse if the patient had been discharged too soon. Upon notification on the day of discharge, THP retrospectively denied coverage after day 4 of the patient's stay, in part, because family/social support therapy was not taking place. As noted in Paras. 8 & 9, on day 4 of the patient's stay, the patient was still exhibiting mild symptoms of opioid withdrawal, the patient's medication assisted treatment was still in flux, and the medication assisted treatment and transitioning was not yet complete. Also as noted in these Paras. 8 & 9, the patient would have been at risk had medication assisted treatment been abruptly discontinued. Finally, this decision did not appropriately take into consideration the patient's complete clinical presentation and lack of family support.

   ii. THP did not give sufficient weight to the clinical recommendations of the attending provider/facility. For example, in one Case Record, THP disregarded the recommendation of the attending physician that continued inpatient treatment was needed, despite clinical information showing that the patient was still showing symptoms of detoxification and

had not yet completed methadone adjustments and transition to buprenorphine and therefore was not appropriate for discharge.

e. Collection of sufficient information.
    i. THP did not consistently gather and then document sufficient information needed to make a clinically appropriate utilization review decision.
    ii. For example, in one Case Record, an adolescent admitted to a residential treatment facility was denied coverage for the entire stay based on THP's conclusion that such treatment was not medically necessary. On the day THP was notified of the admission and performed its concurrent review, THP also conducted a retrospective review of the previous twenty-one (21) days. THP denied the previous twenty-one (21) days and any subsequent days from the day of its review. Based on the documentation in the Case Record, THP's efforts to collect additional clinical and other information were not sufficient in order to make its decision to deny coverage for this stay, information such as success or failure in an outpatient setting and the degree of repeated behavior in the home setting. THP also notes (on or about page 29 of the Case Record) there is no discharge plan in place for this patient. The MGH reviewer found that the clinical information in the Case Record was insufficient for THP to make its denial decision. Additional information to document the provider's clinical judgement for residential treatment would have been critical to understanding the treatment needs of the patient.

f. Impeding care.
    i. THP's third party delegate did not adequately consider continuity and transition of care needs, and the safety and welfare of the patient.
    ii. For example, in one Case Record THPs' third-party delegate denied 14 days of partial hospitalization for a patient with a severe opioid use disorder who was in the process of stepping down treatment at an out of state facility, beginning with inpatient detoxification, followed by residential treatment. The patient had a history of multiple recent relapses, and multiple unsuccessful treatment efforts. The denial rationale states the patient was not having any withdrawal symptoms, could

conduct activities of daily living, did not have any medical issues that required partial hospitalization, was not thinking of self-harm, and was cooperative and appropriate at the facility. Intensive outpatient treatment was offered by the reviewer, but the provider declined. The Examiners found that THP's third-party delegate did not address clinical information demonstrating an addicted patient with multiple relapses at risk of further relapse and harm or death if an appropriate level and quality of treatment were not provided. The Examiners reviewing the case observed that the THP's third-party reviewer applied its utilization review criteria in a clinically inappropriate manner and, had the attending provider not kept the patient at the partial hospitalization for the requested but denied 14 days, the care and safety of the patient could have been impeded.

iii. The Examiners identified three additional Case Records as examples of this practice.

g. Emergency Admissions Documentation

i. THP Case Records frequently include electronic notes/fields showing in a subsection of the "Admission and Discharge Details" section of THP's internal system, a field titled "Admission Type." In this "Admission Type" field, the term "Emergency" is frequently cataloged, giving the appearance that prior certification is required for the emergency admission. These electronic notes give the impression that the "emergency" admission is also pended for additional review, which would be non-compliant with RIGL § 27-18-76 (c)(1).

ii. The Examiners identified one Case Record as an example of THP's use of its electronic note field showing an admission type as an "Emergency Admission". On or about page 2 of the Case Record the documentation further states that a call was received from the attending provider and "Psych admit pended for mental health review." These electronic notes/fields give the appearance that an authorization is necessary for an emergency admission.

iii. The Examiners identified two additional Case Records as examples of this practice.

11. Inadequate documentation.
    a. THP did not adequately document the utilization review process to include the attending provider requests, the full clinical status of patients, and THP's reviewer decision rationales:
        i. The Examiners identified failures to document: (A) the ordering provider's specific service or treatment request; (B) whether the request was approved; (C) whether THP made any modification of the request after a bona fide, voluntary agreement of the provider; and/or (D) THP's clinical rationale for any proposed modification. THP reviewers do not always record the provider's initial request for a specific length of stay at a particular level of care. The Examiners inferred from the absence of documentation in the Case Records, and from THP's description of the utilization review process in a letter to the Examiners dated February 16, 2018, that THP reviews the case initially and on subsequent concurrent reviews and then, based on discussion with the attending provider, determines how long a continued stay is medically necessary. THP asserts that if the attending provider concurs with THP's decision, the case is classified as an approval. Further, if the attending provider objects to THP's decision, THP asserts that the case is classified as a denial. The Examiners were unable to find supporting documentation for the legally required process to document: an attending provider's specific request when made; THP's approval or denial of the specific request; and, if applicable, a clinically-supported modification of the request based on a bona fide, voluntary agreement to modify. For example, one Case Record identified an urgent admission to a psychiatric hospital for worsening depression and suicidal ideation (SI) with a plan to overdose. The initial information on page 7 is not clear on what the attending provider was requesting and if the attending provider agreed to what was authorized. Also, the 4-day authorization by THP does not meet the stated Estimated Length of Stay (ELOS).

ii. The Examiners identified failures to document sufficient detail concerning the patient's clinical condition, history of treatment, and relationships with family members. For example, see Paras., 8(c) and 10(e).

iii. The Examiners identified failures to document the clinical information offered by the treating facility, and the treating facility's rationale for continued treatment. For example, see Para. 10(e).

iv. The Examiners identified failures to document the specific criteria and information used in the denial decision. For example, see Para. 10(a).

b. The Examiners identified five denial Case Records and three authorization Case Records as examples of this practice.

12. Oversight of delegated activities.

a. During the time periods examined, THP administered its utilization review program for behavioral health services for most of its members internally, without relying on delegated third parties. For its utilization review program in states other than MA and RI, however, THP delegated administration of its utilization review program to third-party delegate. THP remained legally responsible for administering its utilization review programs in a reasonable and fair manner, and for complying with state and federal laws and regulations. In order to fulfill these responsibilities, THP needed to ensure that it had an effective oversight program of third-party delegate.

b. There is no persuasive evidence collected by the Examiners that THP engaged in adequate oversight of third-party delegate. For example, there was no evidence that THP reviewed and accepted the behavioral health services criteria or guidelines used by third-party delegate to make medical necessity determinations for members of THP health benefit plans in terms of whether the guidelines or criteria were clinically appropriate. There was no evidence that THP audited Case Records of medical necessity determinations made by third-party delegate for members of THP health benefit plans in terms of whether third-party delegate's guidelines or criteria were applied in a clinically appropriate manner, and in a manner consistent with federal and RI laws and regulations.

c. Each organization appears to have its own very different utilization review criteria and its own very different policies and procedures for administering a

utilization review program. Additionally, there is nothing in the denial and appeal notification letters sent from third-party delegate to patients or providers that would indicate that the patient is enrolled in a THP health benefit plan or that third-party delegate is acting as a delegate of THP. The separate nature of the utilization review program for each entity and the absence of documentation to indicate otherwise suggests that THP's oversight of third-party delegate was not adequate.

d. For example, in one Case Record, the third-party delegate denied a request for continued partial hospitalization for a patient with opioid addiction and a history of multiple recent relapses in treatment and multiple unsuccessful treatment efforts, despite the patient's need and the attending provider's recommendation for a gradual step down to lower levels of care to mitigate risk of another relapse. The third-party delegate denied coverage because treatment at the requested level of care had been unsuccessful in the past. This Case Record supports eight separate findings of non-compliant utilization review practices.

e. In another example, in one Case Record, the third-party delegate denied approval of a patient with opioid addiction for an intensive outpatient program, notwithstanding the patient's risk of relapse, and harm to self. In denying the treatment request, the third-party delegate suggested that the patient had reached "maximum benefit from all these treatments".

f. In Paras. (a) through (e) above, suggests THP's oversight of third-party delegate's administration of the delegated utilization review function was inadequate.

13. Behavioral health parity. With respect to its behavioral health parity obligations during the time period of this Examination, the Examiners noted the following concerns with THP's practices.

a. Based on a review of THP's policy documentation, including Certificates of Coverage in effect during the period of time under examination, the Examiners found reason to be concerned that THP applied its utilization review and care management programs to a broader scope of behavioral health services than was the case with medical surgical services. For example:

i. THP's policies provided for outpatient behavioral health services to be subject to a notification process (i.e. not a medical necessity review) for the first set of 8 visits, however the policies also provided that additional visits were subject to prior authorization. See THP letter dated March 1, 2019. In contrast, many medical surgical outpatient services were not subject to prior authorization and only physical therapy and occupational therapy services were subject to a notification process followed by a prior authorization process after the first set of visits.

ii. Based on the policy documentation presented during the examination period, the Examiners had concerns that THP's application of its utilization review or care management programs to behavioral health services was more stringent than the application of such programs to medical surgical services.

Behavioral health - recommendations.

14. THP shall implement the following Recommendations in order to address the concerns described in Paras. 8 through 13. On or before June 1, 2020, THP shall file a draft Plan of Correction to implement each of the following Recommendations, for the Commissioner's consideration. On or before July 1, 2020, THP shall file a final Plan of Correction approved by the Commissioner to implement each of the following recommendations. The Recommendations shall be implemented in a manner that is consistent with OHIC's Benefit Determination and Utilization Review and Network Plan Certification Regulations, and with the regulations adopted by the Commissioner following completion of the work of OHIC's Administrative Simplification Work Group.

15. THP shall revise its behavioral health utilization review processes in the manner set forth below:

a. THP shall revise its utilization review criteria as necessary to assure compliance with current rules and regulations and to operationalize the use of this criteria to ensure its general medical necessity standard cannot be used to deny services which otherwise meet THP utilization review guidelines.

16. THP shall document and maintain a process that offers providers an opportunity to request approval of a behavioral health service inconsistent with the formal criteria, based on the unique or unusual nature of the patient's clinical condition or circumstances. Such decisions

shall be considered medical necessity decisions. The Utilization Review (UR) Agent physician reviewer shall consider, address, and document all information submitted by the ordering provider in connection with this exceptions process as part of the medical necessity decision.

17. THP shall revise its behavioral health utilization policies and procedures to include the items set forth below. Each revised policy and procedure shall be subject to an explicit component of a utilization review program training manual and training module. Compliance with the revised policies and procedures shall be monitored by an oversight policy, conducted by THP:

a. THP shall revise the manner in which its level of care criteria are applied to patients with opioid addiction, in the following manner (THP should ensure that third-party delegates also conform to these recommendations):
    i. The patient's risk of relapse, overdose, and death should be given appropriate weight and explicit consideration.
    ii. Any utilization review decision should adequately consider (i) the patient's clinical condition, (ii) the attending provider's ("attending provider" shall have the same meaning as "ordering provider" and "treating provider" in this document) treatment recommendation and rationale for the request, (iii) all relevant information offered or included in the record, (iv) continuity and transition of care to include a patient status on a particular Medication Assisted Treatment (MAT) and (v) the safety and welfare of the patient.
    iii. When the material facts and clinical circumstances presented by the attending provider for treatment of opioid addiction are not in dispute, the utilization review decision should not conflict with the attending provider's level of care or length of stay recommendation unless THP substantiates that the provider's recommendation is unreasonable.
b. Notice of Adverse benefit determinations shall clearly identify the specific criteria or criteria subset not met and the facts supporting the reviewer's conclusion that the specific criteria or criteria subset were not met.
c. Ensure that, before any denial or appeal decision is made, a THP physician (if the service and/or treatment request is made by a physician) conducts and documents a thorough and independent review of the case, rather than simply

relying or upholding the observations and recommendations of non-physician case management staff. The THP physician shall review all material clinical information, consider whether all necessary information has been collected, give sufficient weight to the ordering provider's clinical judgment or recommendation, and offer a clinically-based rationale for any denial.

d. The utilization review denial and appeal decision shall adequately consider (i) the patient's clinical condition, (ii) the attending provider's treatment recommendation and rationale for the request, (iii) all relevant information offered or included in the record, (iv) continuity and transition of care, and (v) safety and welfare of the patient.

e. When the material facts and clinical circumstances presented by the attending provider for treatment of a behavioral health patient are not in dispute, the utilization review decision shall not conflict with the attending provider's level of care or length of stay recommendation unless THP substantiates that the provider's recommendation is unreasonable.

f. Ensure that, when the facts and circumstances presented suggest reason to believe that necessary clinical information critical to the utilization review decision is missing, such necessary clinical information should be specifically and reasonably solicited from the provider.

g. The utilization review process shall require THP to explicitly consider and document whether a potential utilization review denial might impede care or delay care.

18. THP shall revise its documentation policy for utilization review records for behavioral health services. Compliance with the case record documentation policy should be an explicit component of a utilization review program training manual and training module. The revised documentation policy should require case records to include:

a. The ordering provider's initial request for service and/or coverage of treatment, including the level of care requested and the number of days requested.

b. Any modification of the ordering provider's initial request made by THP, the clinical rationale for the modification, and the bona fide, voluntary agreement of the provider to the modification.

c. Detail concerning, and/or reasonable efforts to obtain, the patient's clinical condition, history of treatment, and relationships with family members sufficient to make a decision to assure the safety and welfare of the patient.
d. All the clinical information communicated by the treating facility or a provider, and the treating facility's or provider's rationale for treatment, including continued treatment.
e. The specific criteria or criteria subset not met, and the facts supporting the conclusion that the specific criteria or criteria subset were not met.
f. Where a THP physician reviewer has reviewed a case, the independently prepared review of that THP's physician reviewer must be documented. In the event of a denial, the review shall include documentation of (i) all material clinical information reviewed, (ii) the utilization review criteria not met, (iii) the information supporting the denial, and (iv) the reviewer's rationale for rejecting or disagreeing with the ordering provider's clinical judgment or recommendation.
g. Modify the electronic documentation process to more clearly indicate that prior authorization is not required for emergency services and to specify that emergency services are not pended.

19. In addition to those recommendations stated in Paragraphs 15-18 above, THP shall ensure that it and any third-party entity to which it delegates the utilization review function for THP members shall:

a. Have and utilize utilization review criteria that are in compliance with all federal and state laws and regulations, hold a current Rhode Island certification to perform non-administrative benefit determinations, and be audited by THP for compliance with the following utilization review criteria related requirements:
    i. That only objective, clinically-based, and measurable written criteria shall be used to deny requests for behavioral health services.
    ii. Use a clinically appropriate national utilization review criteria set that includes an Estimated Length of Stay (ELOS) component or a comparable process approved by the Commissioner.
    iii. Adopt a criteria set based on national standards and acceptable to the Commissioner.

iv. That the criteria and use of criteria shall provide for the coverage of continued stay or care when there is no treatment setting available for the patient on discharge or if there is a delay in the availability of an essential component of the patient's treatment environment.

v. Assurance that the criteria and use of criteria that does not permit denial of coverage of a continued level of care or length of stay recommendation for a patient because the patient is not participating in treatment when the patient's non-participation may be related to the patient's behavioral health condition.

vi. Assurance that criteria and use of criteria shall not permit the denial of coverage for treatment because the patient has failed in treatment in the past.

b. THP shall ensure that third-party entities maintain and use utilization review policies and procedures that are in compliance with all federal and state laws and regulations, including compliance with the following:

i. There shall be a documented and clinically-based rationale to recommend discharge to a lower level of care prior to the completion of the estimated length of stay where an ELOS is available.

ii. Any decision that does not authorize the provider's request, at the level of care and for the number of days requested, shall be classified as a denial, absent the provider's documented communication of a voluntary agreement to modify the request. When the third-party entity suggests a modification of the request, the third-party entity shall communicate and document a clinically-based rationale for the suggested modification.

iii. There shall be clear and explicit evidence to support a conclusion that the ordering provider has voluntarily agreed to modify the request so as to reduce the requested length of stay or lower the level of care. In the absence of such clear and convincing evidence, the modified request should be considered a denial, not an authorization.

iv. A patient shall not be denied coverage of a continued level of care or length of stay recommendation for a patient (typically leading to a discharge) based on a rationale of lack of progress or improvement,

treatment failure in the past, or lack of participation when the patient non-participation may be related to the patient's behavioral health condition.

v. The third-party entity shall have a process to provide for coverage for continued stay or care when there is no clinically appropriate treatment setting available for the patient on discharge, or if there will be a delay in the availability of an essential component of the patient's treatment environment.

vi. The utilization review process shall require the third-party entity to explicitly consider and document whether potential utilization review decisions might impede care, delay care, fail to ensure continuity of care, or lead to an inappropriate transition of care.

c. THP shall ensure that the documentation policies and procedures of the third-party entity are in compliance with all federal and state laws and regulations, including compliance with the following:

i. Case Records shall include the date, time, and detail of each event in the utilization review process.

ii. Case Records shall document in detail all conversations or other communications with the ordering provider.

iii. When the third-party entity recommends a modification of the ordering provider's request, the Case Record shall document a clinically-based rationale for the recommended modification.

iv. Case Records shall be collected, organized, and maintained in a form and in a manner that permits the Commissioner to readily ascertain compliance with state and federal laws and regulations, and implementation of these Recommendations.

d. THP shall revise its oversight program to include periodic compliance audits of entities delegated any portion of the utilization review function for members of THP health benefits plans. Revised oversight should include review of medical necessity criteria used by the delegated entity to make utilization review decisions to determine whether the criteria are clinically appropriate and reasonably consistent with THP criteria. Audits shall include a review of the utilization review Case Records of the

delegated entity to determine whether the criteria were applied in a clinically appropriate manner, and in a manner consistent with federal and RI laws and regulations.

e. THP shall revise adverse benefit and appeal notifications sent by third party entities to explicitly identify the role of the third-party entity and to clearly identify THP as the member's insurer.

20. THP shall review, and as necessary revise, its scope of behavioral health services subject to prior authorization. To the satisfaction of the Commissioner, THP shall ensure that its utilization review or care management programs are conducted in a manner comparable to, and no more stringent than, its utilization review or care management programs for medical surgical services. THP shall propose for the Commissioner's approval the form, content, and plan year for data collection purposes of a utilization review parity analysis. If feasible, the analysis should be conducted in the following manner. If THP believes that some elements of the following are not feasible or can be substituted with another parity information or analysis, THP shall explain its reasoning as part of its Plan of Correction to the Commissioner's satisfaction:

a. Identify which mental health, substance use disorder, and medical surgical benefits (excluding prescription drug benefits) are subject to utilization review and: (i) describe the utilization program for each mental health, substance use disorder, and medical surgical benefit; (ii) state the number of requests processed for each mental health, substance use disorder, and medical surgical benefit; and (iii) state the number of denials, appeals, and denials on appeal for those requests processed for each mental health, substance use disorder, and medical surgical benefit.

b. Identify which mental health, substance use disorder, and medical surgical benefits (excluding prescription drug benefits) were not subject to utilization review and state the number of claims processed for each mental health, substance use disorder, and medical surgical benefit.

c. For each mental health, substance use disorder, and medical surgical benefit identified in Paras. 20(a) and 20(b), above: (i) state the reasons or other factors actually used in deciding whether or not utilization review would apply: (ii) identify and summarize the data and other information

used to support the reasons or other factors; and (iii) document the decision process.

d. For each mental health, substance use disorder, and medical surgical benefit subject to utilization review identified in Para. 20(a), above, propose a methodology for determining whether utilization review for mental health and substance use disorder benefits are applied no more stringently than utilization review applied to medical surgical benefits. Such a methodology should: (i) use actual utilization review Case Records in comparing the degree of stringentness; (ii) use independent and/or objective providers to conduct the reviews; (iii) compare the time needed to complete utilization review requests for behavioral health services versus medical surgical services; (iv) compare the complexity of making behavioral health requests versus medical surgical requests; and (iv) consider any other appropriate factors in determining the comparable rigorousness of the reviews.

Summary of findings and recommendations - prescription drugs.

Summary of prescription drug findings.

21. During the time periods examined, THP itself conducted the utilization review function for behavioral health-related prescription drugs, rather than delegating all or some of such responsibilities to a third-party utilization review agent.

22. In accordance with the methodology described in Para. 3, above, the Examiners selected 97 prescription drug utilization review Case Records relating to requests for approval of prescription drugs used for the treatment of behavioral health conditions. Of those 97 prescription drug Case Records, 75 cases resulting in an authorization of the request were reviewed by the Examiners. Of those 75 prescription drug authorization cases, 5 were forwarded to the MGH Clinicians for review of clinically-related issues. Of those 97 prescription drug Case Records, 22 were cases resulting in a denial of the request. Of those 22 prescription drug denial Case Records, 5 were forwarded to the MGH Clinicians for review of clinically-related issues. All 97 prescription drug Case Records (authorizations and denials), were reviewed by the Examiners for non-clinical related issues.

23. It is the Examiners' observations of other carriers that delegating the utilization review function to a third party presents challenges to overseeing the quality of the utilization review

program and its impact on patients. By administering the utilization review program itself, THP's utilization review program appears to have fewer negative impacts on patients. For example, of the prescription drug cases referred to MGH Clinicians for review of clinical issues, the MGH Clinicians observed clinical concerns in only one case.

24. The Examiners find that the conduct, policies or procedures described in Paras., 25 through 27 constitute practices which are non-complaint practices under the requirements of RIGL Title 27, Chapter 9.1 (Unfair Claims Settlement Practices Act), the DOH Utilization Review Regulations, or the DOH Plan Certification Regulations.

25. Clinically inappropriate utilization review criteria. THP used clinically inappropriate utilization review criteria for cases identified within the Examination period for some prescription drugs typically prescribed for behavioral health conditions.

a. Medication assisted treatment.

i. The Examiners found that the use of prior authorization for medication assisted treatment of opioid dependence disorders is clinically inappropriate, except in very limited circumstances as allowed for in the Spring 2017 agreement referenced in subparagraph iii, below.

ii. The opioid crisis facing Rhode Island and many other states demands, and has demanded for many years, an urgency by health care providers and health insurance companies that has not always been reflected in their response to the emergency. Furthermore, whatever value there is in imposing utilization review limitations on treatment for opioid dependency is far outweighed by the risk of harm or death to the patient, and negative impact on public health from failing to treat opioid dependent patients without delay.

iii. The Examiners appreciate the willingness of THP and the other Carriers to collaborate with the Office during the Spring of 2017 to eliminate prior authorization requirements for medication assisted treatment.

b. Aripiprazole criteria. The Examiners found that the THP requirement that Seroquel XR be used as an alternative to aripiprazole is clinically

inappropriate, including because aripiprazole does not have the same negative side effects associated with Seroquel XR. The Examiners identified one Case Record as an example of this practice.

c. Exceptions process. THP prior authorization processes and criteria fail to include an adequate opportunity for the prescriber to request a clinically-based exception to these standards given the particular patient's condition and treatment needs. For example, in one Case Record (see also Para 26 (h)) the prescriber requested approval of Seroquel for a patient with a diagnosis of anorexia nervosa, stating that the patient had tried 2 alternative medications which were ineffective. THP denied the request because its criteria excluded approval of the medication for the patient's diagnosis and THP did so without first obtaining and then documenting the prescriber's clinical rationale for the medical necessity of the medication for this patient.

26. Other utilization review practices.

a. Given the insufficient documentation contained in the Case Records, the Examiners found that the cases classified by THP as authorizations could not be confirmed as authorizations, because the Case Records did not specify exactly what dosing, quantity, or duration was approved. Further, THP approval letters did not state the dose and quantity/length approved, (see e.g. ten Case Records demonstrating this practice), and the Examiners could not connect the stated approval in the notification letters to exactly what was requested by the prescriber (in terms of dose and quantity/length of prescription). For example, in one Case Record, THP's approval does not state that the dose and quantity of the medication requested by the prescriber was approved. Page 2 of the Case Record indicates THP "Approved Drug" as Abilify with no specifics to dosing or quantity. In this case the prescriber ordered 20 mg tablets and included a dosing request. (See page 4 of the Case Record). However, the Examiners reviewing the Case Record and/or the patient receiving a notification letter could not discern whether the dosage requested was indeed approved and, absent clear documentation of precise approval,

that Case Record should be classified as a denial. In another Case Record, the prescriber requested Belviq for a patient with a significant obesity condition for a duration of 3-6 months (see page 8 of Case Record). THP approved the medication for a duration of only 2 months (see pages 17 & 30 of the Case Record). Authorizing the drug but not authorizing the full duration of the request is considered a denial. The Examiners identified two additional Case Records as examples of this practice.

b. Language used in approval letters was confusing as to what has been approved. In all cases reviewed by the Examiners approval letters contain the following confusing information: "The authorization above is valid only up to the benefit maximum (e.g. number of visits allowed for a particular service) indicated in the member's benefit document. THP will not provide coverage for visits/services received beyond this maximum...Coverage for additional visits/days/units for this course of treatment will be considered upon request..." These letters should be tailored to pharmacy benefits not visits and services. Also, references to coverage will not exceed beyond some benefit maximum does not assist the consumer or prescriber in understanding the approval details. The Examiners identified nine additional Case Records as examples of this practice.

c. In some cases, THP approval letters were worded in a manner that might compromise the doctor patient relationship. For example, in one Case Record, the prescriber requested Seroquel for a patient. In accordance with THP's two-step prescriber fax form process, THP sent the prescriber a form asking for additional information. The initial fax form request sent by the prescriber asked for the diagnoses, quantity, frequency, strength, and length of this treatment, all which were answered by the prescriber on this form. The denial notification letters, copied to the patient, stated that the request for Seroquel was denied due to the lack of information needed to make the decision and went on to state that THP attempted to get more information, but the prescriber did not respond to this request. Page 8 documents a first attempt at 7:27 AM CST to contact the

prescriber 13 days after the initial fax request and the second RFI sent by THP. There was no answer at the prescriber's office, and it can be reasonably assumed that the office likely was not open. This same note by a THP staff person states a second attempt to contact the prescriber would be made but the denial was made at 7:31AM CST (4 minutes after 1st contact attempt). Another notable fact about this review is that a pharmacist, not a physician, made this denial (see page 2 & 16 of the Case Record). In another Case Record, (see Para 26 (i) & 27(i)), the THP denial letter to the prescriber, copied to the patient, inaccurately states that the patient was not bipolar. At the time this denial letter was sent, THP did not have affirmative information supporting its assertion that the patient was not bipolar. These inaccuracies in denial letters could compromise the doctor patient relationship.

d. In some cases, THP did not gather and consider sufficient information necessary to make an appropriate and safe utilization review decision. For example, in one Case Record, (see also Para 26(i) & (n)), the prescriber requested Belviq for a patient with a severe obesity condition. A fax form seeking additional information was not successfully faxed to the prescriber by THP. THP inadvertently overlooked that its request for additional information was not received by the prescriber and made its decision based on insufficient information. The Examiners identified seven additional Case Records as examples of this practice.
e. THP did not make or document reasonable efforts to reach out to prescribers to obtain the necessary information to make an appropriate and safe utilization review decision. For example, in one Case Record, THP made a telephonic attempt at 10:05 a.m. to contact the prescriber but there was a power outage affecting the prescriber's office and it was conveyed to THP that the office was not expected to re-open until 2 p.m. THP denied the request at 10:36 a.m. The Examiners identified nine additional Case Records as examples of this practice.
f. In some cases, THP did not adequately consider the patient's welfare and safety. For example, in one Case Record, the prescriber requested

approval of suboxone for a patient with opioid addiction. The prescriber noted the pressing need for the patient for the medication by noting "URGENT URGENT" at the top of the request. Opioid addicted patients risk relapse, overdose, and death if medication assisted treatment such as suboxone is not available in a timely manner. The THP prior authorization process did not consider the urgency of the request as well as the welfare and safety of the patient even though RI UR review timelines were met. The Examiners identified nine additional Case Records as examples of this practice.

g. THP did not always adequately consider the patient's need for continuity of care. For example, in one Case Record, (see also Para 25(b)), the prescriber requested approval of Seroquel for a patient with a diagnosis of anorexia nervosa with documented symptoms of insomnia and anxiety, stating that 2 alternative medications had been tried. On or about pages 4 and 5 of the Case Record, the Examiners found strong implications that the patient was being effectively treated with Seroquel. The prescriber statements on these pages (4 and 5 of the Case Record) include that "...Seroquel helps with insomnia..." and "med helps with insomnia an[d] anxiety..." THP denied the request because its prior authorization criteria did not permit approval of the medication for the particular diagnosis. In doing so THP did not consider the patient's need for continuity of care with a medication that the prescriber believed to be effective, did not adequately reach out to the prescriber to confirm if the patient was on the medication (neither fax form sent requesting information asked that specific question nor was the patient's claim history checked), and there was no process to allow for exceptions to criteria in considering the patient's clinical circumstances. The Examiners identified three Case Records as examples of this practice.

h. THP denies requests without documenting evidence of a thorough and independent review by a physician of the information necessary to make a safe denial. For example, in one Case Record, (see also Para 26(e) & (n)), a THP pharmacist, not a physician, reviewed and denied the request,

notwithstanding the physician prescriber's clinical rationale for the medication for this particular patient. The Examiners identified six additional Case Records as examples of this practice. In a further example, in one Case Record, (see Paras. 26 (d) & 27(i)), the denial letter states that it is written by a THP physician who reviewed all the information, but the denial rationale is virtually identical to the denial rationale written by non-physician THP staff. The denial documentation does not evidence that the denial was made following a thorough and independent review by a physician with sufficient information to make a safe denial in terms of the patient's condition. The Examiners identified seven additional Case Records as examples of this practice.

i. THP's prescriber fax form request process often involves a follow-up request by THP for additional information that was not part of the initial request for information and could result in unnecessary delays in utilization review decisions for prescription drugs. Two Case Records identified by the Examiners demonstrated this practice.

j. The Examiners found that THP's prescriber fax form request process does not clearly allow the prescriber to indicate whether the request is urgent. The universal pharmacy request fax form does have an expedited box for 24-hour turnaround for Medicare Preferred members only, but the form does not state that prescribers can access an expedited review time for other lines of business.

k. THP's drug specific Pharmacy Medical Necessity Guidelines state the following: "Previous use of samples or vouchers/coupons for brand name medications will not be considered for authorization." When using this guideline to deny requests for medications that patients have been started on as a result of samples distributed at the prescriber's office, THP may not have provided for the consideration of the continuity of care, health, safety, and welfare of the patient. The Examiners do not condone prescribers' use of samples in this manner, and the Examiners acknowledge that the practice is designed by pharmaceutical manufacturers to increase usage of more expensive brand name

medications; however, if the patient is stable on a medication started with a sample, the patient should not be put in the position to be the party to suffer negative clinical consequences because of behavior of the prescribers and pharmaceutical manufacturers.

l. As a result of the non-compliant utilization review practices described in Paras. (a) through (k), above, care was either or impeded or delayed or was potentially impeded or delayed.

27. Documentation. THP did not always adequately document the utilization review process, and utilization review decisions.

a. For example, in one Case Record, (see also Para 26 (d)(i)), the prescriber sent two fax form requests for quetiapine. THP inadvertently overlooked the second request which had listed a diagnosis of bipolar disorder not otherwise specified with psychotic features, whereas the first request had listed diagnoses of depressive disorder, generalized anxiety disorder, and panic disorder. THP considered the second request as a duplicate and denied the request without documenting that it considered the additional information provided in the second fax form request.

b. As an additional example, in one Case Record, the documentation notes that a THP physician reviewed the case and made the decision to deny the request, however, all of the notes were made by THP case management staff or a THP pharmacist. Furthermore, while the denial letter is electronically signed by the THP physician, the letter refers to the physician in the third person. There was insufficient documentation to support that the case was reviewed and decided by a physician, rather than reviewed and made by non-physician and merely "rubber stamped" by the physician.

c. It was standard practice for THP to not document the dose and quantity for the requested and approved medication. This practice can be found in most authorization cases (see Para 26 (a)).

d. THP failed to document reasonable efforts to reach out to prescribers to obtain the necessary information to make an appropriate and safe

utilization review decision. The Examiners identified nine Case Records as examples of this practice.

Prescription drugs - recommendations.

28. THP shall implement the following Recommendations in order to remediate the non-compliant practices described in Paras. 25 through 27. On or before June 1, 2020, THP shall file a proposed Plan of Correction with the Commissioner to implement each of the following Recommendations set forth in Paras. 29 through 31. On or before July 1, 2020, THP shall file a final Plan of Correction approved by the Commissioner to implement each of the following recommendations.

29. THP shall revise its prescription drug utilization review criteria for medications typically prescribed for behavioral health conditions in the manner set forth below.

a. THP's pharmaceutical formularies will continue to include, at a minimum;
    i. One buprenorphine combination Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphine/naloxone), in a tablet or film form; and
    ii. One buprenorphine (mono-formulation) Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphine) in a tablet or film form.
b. To the extent they exist, THP shall discontinue any prior authorization requirements or programs for the formulary medications identified in Para.29 (a), above, with the limited exceptions that:
    i. THP may propose the adoption of dose limit and supply limit criteria consistent with federal guidelines; however, any such dose or supply limit criteria must allow for the coverage of formulary Medication Assisted Treatment dispensed within FDA recommended dose guidelines without any prior authorization requirements while the prescribing clinician is provided the opportunity to clinically justify a dose outside the guidelines.

ii. THP may establish prior authorization requirements for mono formulation MAT provided that coverage is provided for the mono formulation MAT for pregnant women without prior authorization.

c. In connection with: (i) a member that is already taking a MAT medication not identified in Para. 29(a), above; and (ii) a member that is already taking a MAT medication at a prescribed dose level outside the FDA recommended dose guidelines, THP shall continue to permit such coverage while the prescribing clinician is provided the opportunity to clinically justify continued coverage through the formulary exception process.

d. THP shall revise its utilization review criteria for aripiprazole to ensure that they are reasonable and address the concerns raised in Para., 25(b).

e. The utilization review criteria or process shall include an "exceptions process" that offers prescribers an opportunity to request approval of a medication (or of a quantity, supply, or dose of a prescription drug) inconsistent with the formal criteria, based on the nature of the patient's clinical condition or circumstances. Such decisions shall be considered medical necessity decisions. The UR Agent physician reviewer shall consider, address, and document all information submitted by the prescriber in connection with the exceptions request.

30. THP shall revise its prescription drug utilization policies and procedures for medications typically prescribed for behavioral health conditions, as set forth below. Each revised policy and procedure should be subject to an explicit component of a utilization review program training manual. Compliance with the policies and procedures should be monitored by an oversight policy, conducted by THP.

a. THP shall classify as a denial any utilization review decision that does not explicitly authorize the prescription drug initially requested, or does not explicitly authorize the initially requested quantity, supply, or dose of the prescription drug.

b. THP approval letters shall be revised to reflect an unambiguous approval of the medication initially requested and approved, at the dose and quantity requested.

c. THP shall revise its denial letter content to consider the doctor-patient relationship.
d. THP shall ensure that sufficient information is collected to ensure a safe denial.
e. In making a denial, THP shall consider and document that (i) the denial is consistent with the patient's safety and welfare, (ii) patient care will not be impeded or delayed, and (iii) continuity of care and treatment will not be adversely affected.
f. THP shall establish reasonable policies and procedures around the use of samples, including to ensure continuity of care and the welfare and safety of the patient.
g. THP's prescriber fax form request process shall be revised, as necessary, so as not to result in unnecessary delay in processing requests.
h. THP's prescriber fax form request process shall ask the prescriber whether or not the request is urgent.
i. If the facts and circumstances presented suggest reason to believe that clinical information critical to the utilization review decision is missing, THP shall revise its process to more effectively solicit the necessary information from the prescriber that allows a reasonable period of time for the prescriber to respond. THP shall always ensure that it has sufficient information to make a safe denial with respect to the patient's condition.
j. The utilization review process shall be revised to assure that decision-makers explicitly consider whether a potential utilization review denial might impede care, delay care, fail to ensure continuity of care, or result in an unsafe denial.
k. THP physician reviewers shall conduct and document a thorough, independent review of the prescriber's request, rather than simply relying on the observations and recommendations of non-physician staff. Pharmacists shall not make denial decisions.

l. THP physician reviewers shall explicitly consider all of the information offered by the prescriber, and explicitly consider the rationale stated by the prescriber in support of the approval request.

31. THP shall revise its documentation policy for utilization review records for prescription drugs used to treat behavioral health conditions to include the following requirements. Compliance with the Case Record documentation policy shall be subject to an explicit component of a utilization review program training manual. Compliance with the policy shall be monitored by an oversight policy, conducted by THP.

a. THP medical reviewer shall include documentation of all material clinical information obtained from the prescriber and what was reviewed, the utilization review criteria not met, and the reviewer's rationale for rejecting or disagreeing with the ordering prescriber's request, clinical judgment, or recommendation.

b. THP shall document the prescriber's initial request, including the dose and quantity of the medication requested and any modification of the provider's initial request made by THP, the clinical rationale for the modification, and the bona fide, voluntary agreement of the prescriber to the modification.

c. THP approval letters shall document the dose and quantity of the requested medication.

Order

Wherefore, it is hereby ORDERED:

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

B. On or before June 1, 2020, THP shall file a draft Plan of Correction to implement the recommendations set forth in this Report, for the Commissioner's consideration.

C. On or before July 1, 2020 THP shall file a final Plan of Correction, approved by the Commissioner, to implement the recommendations set forth in this Report.

D. Within 30 days of the issuance of this Order, THP shall file with the Commissioner affidavits executed by each Director of the THP Boards stating under oath that they have received a copy of the adopted Report and related Orders.

E. THP shall implement the Plan of Correction within the time frames set forth in the approved Plan of Correction.

F. The Commissioner shall retain jurisdiction over this matter to take such further actions, and issue any supplemental orders deemed necessary and appropriate to address the Report's findings, and to implement the Report's recommendations, and orders. Such further actions may include but not be limited to validation studies conducted by the Office to verify compliance with these Orders. THP shall pay the costs of any such further actions or supplemental orders.

G. In lieu of a penalty, THP shall make a behavioral health system infrastructure payment in the amount of $150,000 on or before March 31, 2020. This payment shall be made to a non-profit Rhode Island organization agreed to by the Commissioner, under the terms agreed to by the Commissioner. The payment shall be used to improve the behavioral health system, including improving preventative care and timely access to needed care and treatment for individuals with mental health and substance use disorder conditions. The behavioral health infrastructure payment shall be separate from, and in addition to THP's costs of implementing this Report's Recommendations and Orders.

Dated at Cranston, Rhode Island this 21st day of February, 2020.

Marie Ganim

Marie Ganim, Commissioner

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

Consent of Tufts Insurance Company and Tufts Associated

Health Maintenance Organization (THP)

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

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

III. THP acknowledges and agrees that it consents to the legal obligations imposed by this Order, and that it does so knowingly, voluntarily and unconditionally.

IV. Notwithstanding the foregoing, this consent does not constitute an admission of any statement of fact or conclusions of law contained in the Examination Report or Order.

By: Mary O'Toole Mahoney Date: 2/25/2020

Title: Chief Legal officer

TUFTS Health Plan

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Watertown, MA 02472-1508
617.972.9400
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January 24, 2020

Marie Ganim, PHD
Health Insurance Commissioner
Office of the Health Insurance Commissioner
1511 Pontiac Ave., Bldg. #69, 1st Floor
Cranston, RI 02920

RE: Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Disorder Laws and Regulations (OHIC-2014-3)

Dear Commissioner Ganim:

Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively, "Tufts Health Plan") respectfully submit this written response to the Final Report ("Report") issued by the Office of the Health Insurance Commissioner ("OHIC") pursuant to the above referenced Examination. The Report primarily covers the 2014-2015 time period. Tufts Health Plan acknowledges that it has made and will continue to make improvement in its processes since 2014 and will collaborate with the OHIC to file a Plan of Correction in connection with this Report. However, Tufts Health Plan disagrees with several of the factual and legal findings in the Report and denies any inference of wrongdoing in connection with the Examination, particularly as it relates to state or federal mental health parity laws.

Tufts Health Plan takes mental health parity compliance seriously and believes that its practices during the examination period were consistent with federal standards and guidance interpreting the Mental Health Parity and Addiction Equity Act ("MHPAEA"). In keeping with this commitment, Tufts Health Plan maintained, and continues to maintain with limited exception, its behavioral health ("BH") operations and expertise on-site, including dedicated utilization review staff, member services, and care managers. In the course of this Examination, outside of pharmacy case review, Tufts Health Plan produced BH case records from 2014 and 2015, of which only 16 were denials. A total of six (6) BH medical cases over a two-year period serve as the basis for the findings of the Report. No medical/surgical case files were requested.

It has been Tufts Health Plan's consistent practice to carefully consider and limit the requirements it places on access to coverage for behavioral health services. Prior to the period of the Examination and continuing through present day, very few behavioral health services require prior authorization.

In addition, Tufts Health Plan continues to work on building and improving relationships with key behavioral health providers in order to increase access to community-based services. Tufts Health Plan values collaborating with our primary care and behavioral health providers to advance joint initiatives which include integrated care, behavioral health screening, and medication assisted treatment (MAT). For example, we are working with CODAC Behavioral Healthcare to support a MAT telehealth project; bringing Fellowship Health Resources (a Crisis Stabilization Unit

provider) into our network to increase access to urgent care; collaborating with BH Link to ensure access and coordination of care; and are hosting a working breakfast with multiple PCP groups to engage in discussion regarding streamlining behavioral health screening and integrated care in primary care settings. We also continue to work with substance use disorder (SUD) providers and Behavioral Health Developmental Disabilities and Hospitals (BHDDH) of RI to develop Centers of Excellence for SUD treatment.

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

Sincerely,

Mary Mahoney

Mary Mahoney
Senior Vice President, Chief Legal Officer

cc: Thomas Croswell