

**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 ) OHIC-2014-3  
Laws and Regulations )**

**Examination Report of Neighborhood Health Plan of Rhode Island, in  
accordance with R.I.G.L. § 27-13.1-5(b).**

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and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3**

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February 14, 2020

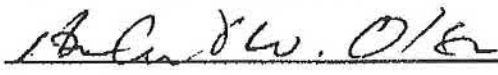
Honorable Marie Ganim  
Health Insurance Commissioner  
State of Rhode Island

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 Neighborhood Health Plan of Rhode Island. Other Examination Reports address compliance by the other carriers.

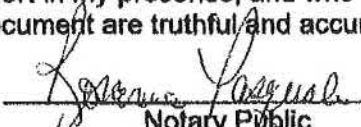
The examination was conducted by Linda Johnson, OHIC Operations Director (as of October 15, 2019 OHIC Independent Contractor), and Herbert W. Olson, Esq. (former OHIC General Counsel), with the assistance of OHIC and EOHHS staff, and with clinical expertise from behavioral health clinicians associated 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

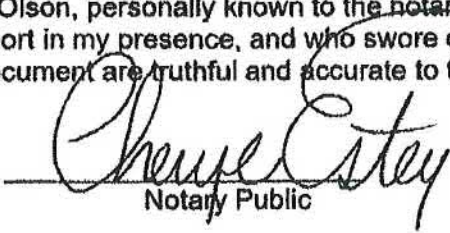
  
Herbert W. Olson, Esq.  
Hillsboro Mountain PLC



On this 20<sup>th</sup> 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





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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 ("OHIC") on January 8, 2015. The Commissioner appointed as Examiners (among others) Linda Johnson, 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" or "NHP"), Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively "Tufts"), 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 Neighborhood. 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 Neighborhood's Examination, however, records and operations during the 2015 and 2016 calendar years were targeted, because Neighborhood did not begin to provide health insurance coverage subject to the jurisdiction of OHIC until 2014, and 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.



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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 Neighborhood 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

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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



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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.



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- 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

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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.



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- d. The Examiners reviewed all utilization review decisions concerning requests for behavioral health services and medications typically prescribed for patients with behavioral health conditions made by, or on behalf of Neighborhood during the examination period. In contrast, the Examiners used sampling techniques for other carriers with a larger market share, number of utilization review decisions, and number of members in RI. No sampling techniques were used for Neighborhood utilization review decisions because of the significantly smaller number of utilization review decisions, and because sampling may have distorted the validity of the resulting findings. 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. Neighborhood was cooperative and professional in its responses to information requested by the Examiners.
- f. A confidential version of this Report includes confidential Working Papers. The Working Papers Appendices consist of Case Record Summaries with Findings of Fact and Conclusions of Law derived from the review of Case Records of specific utilization review events by the Examiners, and by the expert clinicians engaged by the Examiners to assist with the Examination. Working Papers Appendix A consists of Behavioral Health Case Record Summaries. Working Papers Appendix B consists of Prescription Drug Case Record Summaries. The Working Papers are confidential in accordance with RIGL § 27-13.1-5. Among other confidentiality provisions, RIGL § 27-13.1-5 prohibits the disclosure of confidential working papers to anyone for any purpose, other than state or federal insurance regulators that agree to maintain the confidentiality of the documents.

Summary of Findings and Recommendations

Summary of behavioral health findings.



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4. Given the total number of cases subject to utilization review during the Examination period, the Examiners reviewed:

- a. All 106 Case Records classified by Neighborhood as authorizations and submitted to the Examiners;
- b. All 28 Case Records classified by NHP as denials and submitted to the Examiners;
- c. All 11 Case Records classified by Neighborhood as appeals, and
- d. All 9 Case Records classified by NHP as "Pended" and submitted to the Examiners.

5. During the time periods examined, Neighborhood delegated to Beacon Behavioral Health (UR Agent) the utilization review function for behavioral health services. Notwithstanding such delegation, and notwithstanding the UR Agent's independent legal responsibilities under RI's Utilization Review Regulations and Plan Certification Regulations, Neighborhood is responsible for any lack of compliance by the UR Agent with RI health insurance laws and regulations. The UR Agent administered Neighborhood's utilization review program for behavioral health services pursuant to the UR Agent's policies and procedures approved by Neighborhood.

6. The Examiners find that the conduct, policies or procedures described in Paras., 7 through 11 constitute patterns or practices which violate the requirements of RIGL Title 27, Chapter 9.1 (Unfair Claims Settlement Practices Act), the DOH Utilization Review Regulations, and/or the DOH Health Plan Certification Regulations.

7. Utilization review criteria. Based on the information provided during the Examination, the Examiners found that the UR Agent sometimes used clinically inappropriate utilization review criteria for coverage of behavioral health services. The UR Agent sometimes used clinically inappropriate utilization review criteria as evidenced by:

- a. Denials of coverage that were based on subjective, generalized conclusions.
  - i. Based on information provided, it appears that the UR Agent used subjective, generalized conclusions to deny coverage for treatment, rather than objective, clinically measurable criteria.
  - ii. For example, in one Case Record, the patient was admitted to an inpatient facility with a significant decline in functioning and concern for the patient's safety. The patient had a prior history of suicide attempts and refused to answer whether or not the patient had a current plan to commit

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suicide. The UR Agent denied the facility's request for treatment, instead recommending placement in a crisis stabilization unit, concluding that the facility had not shown that the patient could only be treated in an inpatient setting. If the UR Agent had used objective, clinically-based criteria the patient's continued coverage for treatment in an inpatient setting may have been approved.

- iii. As another example, a Case Record demonstrated that a patient at high risk of harm to self or others was denied continued hospitalization because the patient superficially denied suicidal ideation or homicidal ideation yet was distressed and not participating in treatment. The UR Agent's criteria used in this case was not suitable for distinguishing between services that should be approved, and services that should be denied. A patient can be denied continued inpatient treatment coverage because "the member requires 24-hour services of such intensity that can only be met in the hospital", yet the UR Agent can approve coverage of treatment at a lower level of care if the patient's symptoms do not reach the threshold of requiring 24-hour supervision.
- iv. Two additional denial Case Records reviewed by the Examiners demonstrated this practice.

b. Under the utilization review criteria used by the UR Agent, patients were denied continued coverage of hospitalization when there was the likelihood of re-hospitalization.

- i. Based on the information provided, the UR Agent's criteria sometimes permit denial of coverage for continued inpatient treatment unless there is a high likelihood of re-hospitalization.
- ii. For example, in one Case Record, an adolescent patient was refusing to be discharged to a less restrictive treatment setting, preferring instead to go home. The facility requested to continue the patient's stay while a safe discharge plan could be arranged. The UR Agent denied the request, using criteria that, in part, require a high likelihood of hospital readmission in order to support continued inpatient treatment. Such criteria do not account for the adverse outcomes that might occur if appropriate treatment is not maintained as initially requested by the treating provider.



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One additional denial Case Record reviewed by the Examiners demonstrates this practice.

- c. The utilization criteria used by the UR Agent's discharge criteria allowed the denial of coverage when a patient was not participating in treatment.
  - i. The UR Agent's criteria allowed a denial of coverage for any level of care if the patient is not participating in treatment, without properly considering and documenting whether the patient's failure to participate was due to clinical factors, or other factors beyond the control of the patient. Such criterion is not clinically appropriate and patients should not be denied continued coverage under these circumstances.
  - ii. The two Case Records noted in Paras. 7(a)(iii) and 7(b)(ii) demonstrated this practice.
- d. "Lack of progress or improvement" denials of coverage.
  - i. The UR Agent denies coverage of requested services based in part on a conclusion that the patient has not made sufficient progress in treatment, without evidence that the UR Agent properly considered and documented whether the patient's insufficient progress was due to clinical factors, or other factors beyond the control of the patient.
  - ii. For example, in two Case Records for the same patient (one was an appeal case record and the other was a denial case record), the patient was admitted to the emergency room as a danger to self and others, with a primary diagnosis of major depression. After 8 days of hospitalization, the UR Agent staff referred the case to the medical reviewer, because of the patient's "length of stay and lack of progress". the UR Agent denied the request for continued coverage of inpatient treatment for the patient's clinical condition
  - iii. Two additional denial Case Records demonstrated the use of "lack of progress" as a factor in denying continued coverage of treatment.
- e. "Convenience of the patient" denials of coverage.
  - i. The UR Agent sometimes denies requests for treatment authorizations, at least in part based on a conclusory, and clinically irrelevant observation that continued treatment is "for the convenience of the patient".



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- ii. For example, in one Case Record, a patient was admitted to an inpatient facility following a suicide attempt. After 10 days of treatment, the facility requested an additional 4 days of coverage at the inpatient treatment level because, despite some improvement in the patient's condition: (i) the patient's judgment and insight was "fair", (ii) the patient could not "contract for safety" upon discharge from the facility, (iii) and the patient was expressing suicidal thoughts about being discharged. The UR Agent medical reviewer denied continued inpatient care, in part because "days are not to be authorized for the convenience of the member or family." The "convenience" rationale is in conflict with the transition difficulties sometime inherent in the mental health condition of seriously disturbed patients. In this case the patient's intransigence was a function of the mental condition, not a desire for a more "convenient" environment.

8. Application of utilization review criteria. Based on the information provided to the Examiners, The UR Agent sometimes applied its utilization review criteria in a clinically inappropriate manner. This inappropriate application of the utilization review criteria occurred when:

- a. Coverage at the point of discharge without an available treatment alternative.
  - i. Based on the information provided, the UR Agent sometimes denied coverage for continued treatment when an alternative appropriate treatment environment was not available.
  - ii. In one Case Record, a patient was admitted for detoxification, with a dual diagnosis of depression. Following detoxification, the facility requested a continued stay until the patient could be safely discharged to a sober living arrangement. the UR Agent denied the request for coverage, stating that while it was "sensitive to the psychosocial situation, the UR Agent could not support continued stay simply to facilitate placement." The facility's request was not merely to facilitate placement, but rather to permit a safe discharge of the patient to a clinically appropriate environment, thereby mitigating the risk of relapse. The facility continued to treat the patient for 3 days until the patient's discharge to a sober living placement.

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- iii. One additional denial Case Record reviewed by the Examiners demonstrates this practice.
  - b. Incorrect application of clinical information to utilization review criteria.
    - i. Based on the information provided, the UR Agent's medical reviewers sometimes did not correctly recognize the nature of the patient's symptoms, and thereby did not apply the information to the criteria in a clinically appropriate manner.
    - ii. In one Case Record, the UR Agent concluded that the patient was not experiencing withdrawal symptoms. If the patient's symptoms had been correctly identified as withdrawal symptoms the request for detoxification services would not have been denied.
    - iii. Two additional Case Records reviewed by the Examiners demonstrate this practice.
  - c. Denial of continued coverage when appropriate lower level treatment setting is not available.
    - i. The UR Agent sometimes did not adequately consider that some patients may need to stay at a higher level of care for at least a short amount of time until an appropriate post-discharge treatment and living environment becomes available.
    - ii. For example, the UR Agent denied continued inpatient stay for a patient with a major depressive disorder, psychosis, alcohol dependence, and suicidal ideation. The treating provider recommended 3 days of continued stay while waiting for a partial hospitalization program to become available in order to avoid relapse for the patient. The UR Agent's coverage decision was made without adequately considering the clinical consequences of discharging the patient to an unsupportive environment.
    - iii. Two case records demonstrate this practice.
9. Other utilization review practices that demonstrated non-compliance with statutory and regulatory requirements. Based on the information provided during the Examination, the Examiners found that the UR Agent engaged in other utilization review practices and procedures that were not in compliance with statutory and regulatory requirements. For example:



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a. Absence of a voluntary, bona fide agreement by the provider to modify the provider's original request.

- i. In all but a few of the 106 authorizations reviewed by the Examiners where the provider's request may have been modified by the UR Agent , one of the following notations are made in the Case Records: (i) "Provider was verbally notified [of Beacon's decision modifying the service request] and agreed to auth [authorize] and will notify member"; (ii) the provider "request, receive, and agree" to Beacon's decision for treatment/services.", or (iii) "Provider informed [of Beacon's decision] and agrees to terms of auth."
- ii. These notations suggest, and the Examiners so find, that the provider made a request that was not accepted by the UR Agent, and from the documentation provided, it could not be determined that the provider entered into a voluntary, bona fide agreement to modify the provider's original request as required by RI laws and regulations.
- iii. In one Case Record the facility requested approval for admission to an in-patient facility for a patient with visual and auditory hallucinations. The UR Agent reduced the number of days requested by the facility, but the decision to reduce the facility's request was made before communications with the facility. After being informed of the decision to reduce the number of days approved, the Case Record documents that the facility "agreed." The Examiners find that that the UR Agent did not secure the agreement of the facility to reduce the number of days initially requested.
- iv. The Examiners identified 11 additional Case Records demonstrating this practice.

b. Absence of a clinical basis to support the UR Agent 's modification of the provider's request.

- i. As stated in Para. 9(a), above, in all but a few of the 106 authorizations reviewed by the Examiners where the provider's request was modified by the UR Agent, the UR Agent modified the provider's request without a voluntary, bona fide agreement with the provider. In addition to modifying the request, in these cases the UR Agent also did not demonstrate a



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clinical basis for modifying the provider's original utilization review request as required by RI laws.

c. Denials of coverage incorrectly classified as authorizations.

- i. A denial is any utilization review decision not to authorize a requested health care service. DOH Utilization Review Regulation § 1.2. Correctly classifying cases as denials ensures that patients and providers will be afforded their statutory and regulatory right to appeal.
- ii. In most of the 106 authorizations reviewed by the Examiners, the UR Agent did not obtain a voluntary, bona fide agreement to modify the provider's original request. These cases, therefore, constitute denials of the providers' request. In the absence of documentation to show a voluntary, bona fide agreement to modify the provider's original request, Neighborhood did not classify these cases as denials in accordance with the RI laws and regulations.
- iii. In one Case Record, the UR Agent approved coverage for 5 days of initial treatment without documented evidence of the length of time requested. In the absence of an adequate demonstration that the provider's request was approved, UR Agent 's decision should have been classified as a denial of coverage. Two other Case Record examples were also detailed by the Examiners.

d. Inadequate consideration of the treating provider's clinical judgement.

- i. The UR Agent sometimes did not adequately consider the clinical judgement of the treating provider when there was no material dispute concerning the facts and clinical information relating to the patient. This practice conflicts with the fundamental purpose of the requirements of peer to peer review set forth in RI laws and regulations.
- ii. In one Case Record a patient was brought to the emergency room with significant psychotic symptoms. The facility recommended admission, but the UR Agent denied the request for coverage. There was no dispute as to the material facts concerning the patient's condition; however, UR Agent disagreed with the facility's clinical recommendation and the case did not contain evidence that there was adequate consideration of the AP's clinical rationale for the request.

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- iii. Five additional denial Case Records demonstrated this practice.
- e. Short-term, frequent concurrent reviews.
  - i. The UR Agent completed short-term, frequent concurrent reviews seemingly without a clinical basis to support the frequency of reviews, or their short-term nature as required by RI laws.
  - ii. In one Case Record, a seriously disturbed patient with declining functionality was subjected to frequent reviews (6 concurrent reviews over a 4-week period). The provider described the patient's clinical condition during this time period as regressing at times, and only slowly improving.
  - iii. Eight Case Records demonstrated the UR Agent's pattern of practice of short-term, frequent concurrent reviews without a clinical basis to support the reviews.
- f. Impeding care.
  - i. The UR Agent's non-compliant utilization review practices could have resulted in impeding of patient care.
  - ii. In one Case Record an adolescent patient was admitted to an inpatient facility following a suicide attempt. While the facility was planning on discharge to a residential treatment center, the UR Agent denied coverage of continued stay based on medical necessity and "for the convenience of the patient". The patient's care could have been impeded but for the facility's decision to permit the patient to remain, without compensation.
  - iii. Three additional denial Case Records demonstrated this practice.
- g. Insufficient justification for pending cases.
  - i. As required, a prior authorization request may be pended if the provider does not include sufficient information to process the request. In several cases reviewed by the Examiners, however, the UR Agent delayed making a decision because of administrative reasons. Though, in each instance, no medical necessity authorization request was pended, the case itself was pended during the utilization review process and the case record does not clearly document or communicate the impact of this "Pended" classification on the approval of coverage for the requested



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services. As a result, the provider and the patient were not afforded all the standards and procedures called for under RI laws and regulations.

- ii. Six additional Case Records demonstrated the UR Agent's practice of improper use of a "Pended" classification.
- h. Providers are not notified in writing of the opportunity to appeal a denial of coverage.
  - i. The UR Agent offers the patient an opportunity to appeal an adverse benefit determination, but not the provider as required by RI laws and regulations. In addition, the UR Agent requires that if the patient wants his or her provider to appeal on his or her behalf, the patient must authorize the provider to do so in writing which is not compliant with RI laws and regulations.
  - ii. Denial cases reviewed by the Examiners demonstrate this pattern of practice to include 24 other Case Record examples.
- i. Patients are incorrectly told that they can appeal a denial of coverage to the RI EOHHS.
  - i. In several cases reviewed the UR Agent informed patients in its notice of adverse benefit determination that if they disagree with the decision, they can appeal to the RI EOHHS. Patients should have been told that an appeal can be made internally within the UR Agent, and then to an external appeal agency. DOH Utilization Review Regulation §§ 6.0 and 7.0.
  - ii. Three other Case Records demonstrated this practice.
- j. Failure to gather sufficient information.
  - i. The UR Agent sometimes did not gather sufficient information needed to make a clinically appropriate utilization review decision as required by RI laws and regulations.
  - ii. In one Case Record a patient with opioid addiction was denied admission to a detoxification facility. The UR Agent did not gather any medical records or clinical information from the detoxification facility in order to make a more accurate assessment of need for a patient who, after being recently discharged from a different facility, had maintained sobriety for only 6 days.

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- iii. One additional denial Case Record demonstrated this practice.
- k. Failure to adequately consider all information presented.
  - i. When making a denial of coverage, the UR Agent does not always consider all information presented concerning the patient, including consideration of the rationale and clinical information offered by the treatment provider as required by RI laws and regulations.
  - ii. In one Case Record the treating provider wanted to discharge a patient admitted with multiple mental health diagnoses and a high risk of harm to self and others to a clinically-appropriate partial hospitalization program but needed an additional 2 days of inpatient treatment in order to arrange for a safe transition. Instead, the UR Agent denied the request for coverage, leaving the patient with no options other than returning home to a non-supportive environment. The UR Agent either did not consider, or consciously re-interpreted clinical information showing that the patient continued to be a serious risk of harm to self.
  - iii. Sixteen other denial Case Records demonstrated this practice.
- l. The peer to peer review processes did not ensure providers were not overly influenced
  - i. When Beacon clearly communicates to providers that only a lower level of care will be approved, providers may be unduly influenced or pressured from following through on what they believe is the clinically appropriate level of care for the patient, and from disagreeing with Beacon's modification of the original provider request and this practice is not in compliance with RI laws and regulations.
  - ii. In one Case Record the treating provider requested a lower level of care because the UR Agent had indicated that only that level of care would be approved. The UR Agent denied this case for the lower level of care even though it was not available and then subsequently, and only then, did the UR Agent authorize the provider's initial level of care request. Notable is that the UR Agent denied the initial request before knowing the availability of the lower level of care.
  - iii. Four other denial Case Records demonstrated this practice.



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m. Failure to state the principal reason for denial of coverage; clinically inappropriate denial letters.

- i. The UR Agent 's denial letters did not state the principal reasons for the denial of coverage, as required by RI laws and regulations.
- ii. In one Case Record a patient was denied coverage for admission and treatment at an inpatient facility after the UR Agent did not adequately reach out to the provider to obtain the clinical information needed to make the utilization review decision. The UR Agent 's notification letter stated that the treatment coverage request was denied because "You do not meet Beacon's level of care criteria for Inpatient Mental Health Services", but the letter does not state the specific criteria not met.
- iii. Two other Case Record examples were detailed by the Examiners.

n. Transition and continuity of care considerations, safety and welfare.

- i. The UR Agent did not adequately consider the patient's need for transition and continuity of care, and the patient's safety and welfare, when denying a requested service, as is required by RI laws and regulations.
- ii. In one Case Record a homeless patient with diagnoses of alcohol dependence and depressive disorder was denied continued coverage for treatment, as the UR Agent found that the patient no longer met medical necessity for inpatient care. The treating facility had identified a sober living environment supportive of the patient's need for continued treatment, but the UR Agent denied the facility's request, reasoning that although the UR Agent was "sensitive to the psychosocial situation, Beacon could not support continued stay simply to facilitate placement." In making the denial of coverage, the UR Agent may have not considered the patient's obvious need for transition and continuity of care, and the patient's safety and welfare.
- iii. Six additional denial Case Records demonstrated this practice.

o. Inadequate peer to peer procedures.

- i. The UR Agent 's peer reviewers are required to make at least two reasonable attempts to communicate with the provider requesting approval of services for the patient. The UR Agent says that it makes

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two attempts within only four hours to communicate with the provider. In practice, the time between attempts to contact the provider is often shorter. Such practices do not constitute "reasonable attempts" to communicate with the provider.

- ii. In one Case Record, the UR Agent 's peer reviewer called the facility where the patient had been admitted at 10:10 pm during a holiday weekend. A follow-up call was made at 10:35pm, after which no further attempts were made to contact the requesting provider. The UR Agent 's attempts to contact the provider were not reasonable under the circumstances, including the time of day, day of the week, and possible time limitations and conflicting responsibilities faced by the facility and providers.

- iii. Eight additional denial Case Records demonstrated this practice.

- p. Impeding care. As a result of the UR Agent 's non-compliant utilization review processes, described in Paras., 7 through 9, above, the UR Agent processes could have potentially impeded or delayed care.

10. Inadequate documentation. Based on the information provided during the Examination, the Examiners found that the UR Agent did not adequately document its utilization review decisions as required by RI laws and regulations.

- a. Provider request. In most cases, the UR Agent did not document the specific number of days of service requested by the patient's provider. Ten Case Records were identified by the Examiners to demonstrate this practice.
- b. Provider rationale for request. In most cases, the UR Agent did not document the providers' rationale for the request, and the clinical details supporting the provider's request.
- c. Incomplete or erroneous information.
  - i. The UR Agent 's documentation of case information provided to the Examiners was not compliant with RI laws and regulations.
  - ii. The UR Agent 's documentation demonstrates incomplete patient medical records, and incomplete or erroneous clinical and transitional information. Sixteen Case Records demonstrated this practice.
  - iii. The UR Agent 's documentation demonstrates missing electronic notes and incomplete submission of Case Records as requested by the



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Examiners, inadequate recording of the date, time and detail of utilization review events and inadequate documentation of communications with providers. Sixteen Case Records demonstrated this practice.

- iv. The UR Agent did not document appeals, even though the denial record showed that an appeal was made.
- v. Three denial Case Records demonstrated this practice.
- d. Failure to document the provider's agreement to modify.
  - i. The UR Agent's Case Records do not document the required bona fide, voluntary agreement with the provider to modify the number of days or level of care initially requested. Instead, Case Record notes make statements such as "the provider was notified and agreed", or "provider was verbally notified of services, authorized and agrees to it". These statements do not constitute sufficient evidence of a bona fide, voluntary agreement to modify the original request. In fact, these statements suggest, and the Examiners so find, that the UR Agent decided on the services it would approve before communications with the provider and regardless of the provider's treatment recommendation.
  - ii. Eleven Case Records demonstrated this practice.

11. Behavioral health parity. Based on the information provided during the Examination, the Examiners found that, with respect to its behavioral health parity obligations, Neighborhood sometimes did not fully comply with RI or federal laws as follows:

- a. Neighborhood denied requests for approval of residential treatment coverage, stating that residential services were not a covered benefit, which may be in violation of state and federal behavioral health parity laws and regulations. In one Case Record, the UR Agent denied approval for a patient who was being discharged from a crisis stabilization unit to be treated in a substance abuse residential treatment center. One other case also demonstrated this practice. This non-compliant practice could have occurred in other cases, but those cases (because they were classified as administrative denials) would not have been sent to the Examiners.
- b. Neighborhood applies its utilization review program to a much broader scope of behavioral health services than is the case with medical surgical services.

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Utilization review is applied to potentially deny coverage to the entire spectrum and continuum of care for patients with behavioral health conditions. Even outpatient services are subject to prior authorization after 12 annual visits. No other comparable medical surgical services are subject to a treatment limitation based on the number of treatment services. In contrast, utilization review of medical surgical levels of care is applied uniformly only to hospitalization and post-hospital settings, leaving some intensive hospital outpatient surgery and services, and some intensive procedures conducted in a doctor's office unaffected by the utilization review process.

- c. The Case Records reviewed by the MGH Clinicians and the Examiners showed that there is reason to believe that Neighborhood applies its behavioral health utilization program in a manner that is more stringent than the manner in which it applies its utilization review program to medical surgical services.
- d. Four Case Records reviewed by both the Examiners and the MGH Clinicians demonstrated this practice

Behavioral health - recommendations.

12. Neighborhood shall implement the following Recommendations in order to remediate the violations described in Paras. 7 through 11. On or before June 1, 2020, Neighborhood 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, Neighborhood shall file a final Plan of Correction approved by the Commissioner to implement each of the following recommendations.

13. Neighborhood shall establish revised behavioral health utilization review criteria, in the manner set forth in (a) through (j), below:

- a. Only objective, clinically-based, and measurable written criteria shall be used to deny requests for behavioral health services.
- b. Level of care criteria shall ensure that if clinically-based admission or continued stay criteria have been met, other portions of the criteria cannot over-ride the admission or continued stay criteria.
- c. Neighborhood shall adopt a clinically appropriate national utilization review criterion set which includes an Estimated Length of Stay (ELOS) component when available or a comparable process approved by the Commissioner (Referenced herein as ELOS shall include a comparable process as approved by



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the Commissioner). The criteria set shall be adopted and used as established by the national entity, rather than as modified by the utilization review vendor, except where necessary to reflect the clinically appropriate recommendations proposed by RI and national providers and interested parties, and except as necessary to implement the recommendations of this Report.

- d. Utilization review criteria shall not permit denial of coverage for continued stay or care if there is no 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.
- e. Criteria shall not require a high likelihood of re-hospitalization in order to approve continued hospitalization.
- f. Criteria shall not allow for denial of continued coverage primarily on the grounds a patient is not participating in treatment when the patient's non-participation may be related to the patient's behavioral health condition.
- g. Criteria shall not allow for denial of continued coverage of a patient for "lack of progress or improvement".
- h. Criteria shall not allow for denial of coverage of a patient because continued stay is "for the convenience of the patient" when transition planning has not been completed, or a safe discharge is not available.
- i. The criteria shall include an "exceptions policy" (this policy shall not be confused with the formulary exceptions process defined in RIGL § 27-18.9-7(b)(6) and 45 CFR § 156.122(c)) 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 the exceptions request.
- j. The process for soliciting comments from Rhode Island behavioral health providers concerning proposed utilization review criteria shall be revised to improve the comment process in order to increase transparency. Prior to the effective date of the adoption or revision of criteria, the process shall require Neighborhood to fully consider all objections, comments and recommendations

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concerning the criteria. The process shall include implementation of the rules and regulations promulgated pursuant to R.I. Gen. Laws § 27-18.9.

14. Neighborhood shall establish revised behavioral health utilization policies and procedures, in the manner set forth in (a) through (l), 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 Neighborhood:

- a. The practice of frequent, short duration concurrent reviews unrelated to the clinical condition of the patient shall be prohibited. Where available, criteria shall include generally accepted ELOS components, and concurrent reviews shall not be conducted prior to the completion of the ELOS, absent a material change in clinical circumstances. Where ELOS components are not available, concurrent reviews shall not be conducted prior to the treating provider's ELOS unless it can be demonstrated and documented that the provider's estimate is clearly unreasonable, based on the clinical condition of the patient. The criteria shall account for dually diagnosed patients.
- b. Denial decisions shall be supported by, and not in conflict with, the facts, observations, clinical records, and other information in the Case Record.
- c. There shall be a documented and clinically-based rationale to recommend discharge to a lower level of care prior to the estimated length of stay, where an ELOS is available.
- d. If the facts and circumstances presented suggest reason to believe that necessary clinical information critical to the utilization review decision is missing, such clinical information shall be actively solicited from the provider.
- e. The utilization review decision shall adequately consider (i) the patient's clinical condition, (ii) the treating provider's treatment recommendation and rationale for the request, (iii) all relevant information offered or included in the record.
- f. When the material facts and circumstances are not in dispute, the utilization review decision shall not conflict with the treating provider's level of care or length of stay recommendation unless the provider's recommendation is clearly unreasonable.
- g. 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



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provider's documented communication of a voluntary agreement to modify the request. When Neighborhood suggests a modification of the request, Neighborhood shall communicate and document a clinically-based rationale for the suggested modification.

- h. There shall be clear and explicit evidence to support a conclusion that the treating 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 shall be considered a denial, not an authorization.
- i. Neighborhood shall not deny a request for coverage of a continued stay if 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.
- j. A patient shall not be denied coverage solely based on the rationale that the level of care is primarily custodial treatment unless the provider's recommendation is clearly unreasonable. Neighborhood's utilization review policy shall explicitly address safe transitions of care when a provider is recommending discharge plan.
- k. The utilization review process shall require Neighborhood to explicitly consider and document whether or not a potential utilization review denial might impede care, delay care, fail to ensure continuity of care, or lead to an inappropriate transition of care.
- l. Neighborhood shall revise its appeal notice procedures to ensure that patients and providers are correctly notified of their appeal rights.

15. Neighborhood shall establish a revised documentation policy for utilization review records ("Case Records") for behavioral health services. Compliance with the Case Record documentation policy shall be an explicit component of a utilization review program training manual. Compliance with the policy shall be monitored by an oversight policy, conducted by Neighborhood. The revised documentation policy shall include the following requirements:

- a. Case Records shall include the date, time and detail of each event in the utilization review process.
- b. Case Records shall include the specifics of the initial provider request, and any modifications to the initial request.

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- c. Case Records shall document in detail all conversations or other communications with the treating provider.
- d. Case Records shall document in detail all clinical information offered by the provider, and the complete rationale for the provider's request for approval of services.
- e. Case Records shall include the independently prepared review of the Neighborhood physician reviewer. 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 requesting provider's clinical judgment or recommendation.
- f. When Neighborhood recommends a modification of the treating provider's request, the Case Record shall document a clinically-based rationale for the recommended modification.
- g. The Case Record shall document the treating provider's express communication of a voluntary agreement to modify the provider's request. Neighborhood's statement or "verification" of the provider's agreement alone shall not satisfy this documentation requirement.
- h. Case Records shall be collected, organized, and maintained in a form and in a manner which permits the Commissioner to readily ascertain compliance with state and federal laws and regulations, and implementation of these Recommendations.

16. Neighborhood shall revise and narrow the scope of behavioral health services subject to prior authorization. Neighborhood shall ensure that its utilization review program is conducted in a manner comparable to, and no more stringent than, its utilization review program for medical surgical services. Neighborhood 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 shall be conducted in the following manner. If Neighborhood believes that some elements of the following are not feasible, Neighborhood shall explain its reasoning 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



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- 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. 16(a) and 16(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. 16(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 comparable medication surgical benefits. Such a methodology shall: (i) use actual utilization review case records in comparing the degree of stringency, (ii) use independent 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 (v) consider any other appropriate factors in determining the comparable rigor of the reviews.

Summary of findings and recommendations - prescription drugs.

Summary of prescription drug findings.

17. During the time periods examined, Neighborhood itself conducted the utilization review function for behavioral health-related prescription drugs.

18. In accordance with the methodology described in Para. 3, above, the Examiners selected 104 prescription drug utilization review case records relating to requests for approval of prescription drugs used for the treatment of behavioral health conditions. Of those 104

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prescription drug case records, 62 cases resulting in an authorization of the request were reviewed by the Examiners. Of those 62 prescription drug authorization cases, 6 were forwarded to the MGH Clinicians for review of clinically-related issues. Of those 104 prescription drug case records, 37 were cases resulted in denial of the request. Of those 37 prescription drug case records, 13 were forwarded to the MGH Clinicians for review of clinically-related issues. Of those 104 prescription drug case records, 5 cases resulting in an appeal of an initial denial were reviewed by the Examiners. Of those 5-prescription drug appeal case, all 5 were forwarded to the MGH Clinicians for review of clinically-related issues. All 104 prescription drug case records (authorizations and denials), were reviewed by the Examiners for non-clinical-related issues.

19. The Examiners find that the conduct, policies or procedures described in Paras. 20 through 23 constitute patterns or practices that violate 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.

20. Utilization review criteria. Based on the information provided during the Examination, the Examiners found that Neighborhood used clinically inappropriate utilization review criteria for prescription drugs typically prescribed for behavioral health conditions and this practice is not compliant with RI laws and regulations.

- a. No formal utilization review criteria. During the examination period, Neighborhood did not establish, in a satisfactory manner, in accordance with and as required by DOH Utilization Review Regulations, formal utilization review criteria for use in the prior authorization of prescription drugs typically prescribed for patients with behavioral health conditions. Instead, Neighborhood used a Pharmacy and Therapeutics Committee (P&T Committee), to develop prior authorization standards but these were not established in accordance with health insurance laws and regulations, but rather seem to have been adopted as Medicaid standards. Further, Neighborhood appears to have applied statutes pertaining to Medicaid, not commercial insurance, in adopting these standards.
- b. Medication assisted treatment.
  - i. The use of prior authorization for medication assisted treatment of opioid dependence disorders is clinically inappropriate.
  - ii. The use of a more stringent prior authorization process for medication assisted treatment for opioid dependence disorders than for comparable



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medications for medical surgical conditions violates state and federal parity requirements.

- iii. 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.
  - iv. The Examiners appreciate the willingness of Neighborhood and the other Carriers to collaborate with the Office during the Spring of 2017 to eliminate prior authorization requirements for medication assisted treatment.
  - v. Two Case Records demonstrate inappropriate denials for patients with opioid addiction.
- c. Exceptions policy. Neighborhood's prior authorization standards do not include an opportunity for the prescriber to support a clinically-based exception to the standards, given the particular patient's condition and treatment needs, in accordance with RI laws.
- d. Vyvanse criteria. Neighborhood's standards for Vyvanse were clinically inappropriate because: (i) the requirement for trials of alternative medications does not offer trial options for first line medications, (ii) there is no clinical basis to support Metadate CD as an alternative medication, and (iii) Neighborhood's standards do not recognize the use of Vyvanse as a harm reduction strategy for patients who might be at risk for abusing other stimulant medications. Two additional Case Records reviewed by both the Examiners and the MGH Clinicians demonstrated this practice.
- e. Latuda criteria. Neighborhood's standards for Latuda are clinically inappropriate because: (i) for a patient in the depressive phase of a bipolar disorder Latuda is one of only two FDA approved medications, (ii) the requirement of a "recent" trial is not defined, and (iii) it is clinically inappropriate to require a re-trial of a medication that has either been ineffective or results in adverse reactions. One

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Case Record reviewed by both the Examiners and the MGH Clinicians demonstrated this practice.

- f. Duloxetine criteria. Neighborhood's standards for duloxetine are clinically inappropriate inasmuch as they deny a prescriber's request for the medication at a lower dose so that the patient could take the medication twice per day. The lower dose is frequently prescribed because of half-life and tolerability considerations. One Case Record reviewed by both the Examiners and the MGH Clinicians demonstrated this practice.
- g. Step therapy or "tried and failed" requirements. Neighborhood's requirements that the patient has been "tried and failed" on preferred medications are excessive. As an example, on one Case Record the standards for Latuda required that the member try and fail 5 separate medications "for an adequate duration" before the prescriber's request for a non-preferred medication could be approved. Another example documented that Neighborhood imposed its "tried and failed" requirements for a patient that had been successfully treated with the requested medication for 6 years.

21. Application of utilization review criteria. Based on the information provided during the Examination, the Examiners found that Neighborhood applied their utilization review criteria in an inappropriate manner and this practice is not compliant with RI laws and regulations

- a. Neighborhood denied requests even though the fax form standards for approval were met. A Case Record example reviewed by the Examiners to demonstrate this practice.
- b. Neighborhood denied medication requests even though the request was for continued therapy. Two Case Records were reviewed by the Examiners to demonstrate this practice.

22. Other non-complaint utilization review practices.

- a. Cases were classified as authorizations, when they should have been classified as denials in accordance with RI laws and regulations.
  - i. In one Case Record the prescriber requested approval of a non-preferred medication, stating that the patient had been tried on other medications with unsatisfactory results. Neighborhood approved the medication, but only for one month. In approving the medication for one month, Neighborhood asked the prescriber to consider a low dose of the



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medication. While the Case Record does not indicate the provider's supply request, in the absence of documentation of the prescriber's request, and in consideration of Neighborhood's Case Record notes, the Examiners find that the prescriber requested a longer supply of the medication. The case should have been classified as a denial. Another Case Record reviewed by the Examiners is an example of this practice.

- b. Neighborhood did not follow required steps in the utilization review denial and appeal process in accordance with RI laws and regulations.
  - i. In one Case Record the prescriber requested approval for coverage of dexamethylphenidate for a patient with attention deficit disorder. The request was initially denied. Subsequent notes show that the provider submitted "new information" warranting an overturn of the initial denial. Additional notes reveal a peer to peer occurred between the ordering provider and NHP. The fax form request was made 8 days before Neighborhood overturned the initial denial. No appeal Case Record of this request was sent to the Examiners. The case should have been classified as a denial overturned on appeal, rather than an authorization. The authorization Case Record contains insufficient information to demonstrate that legal requirements for denials and appeals were complied with. In the absence of such information, the Examiners find that those requirements were not complied with.
  - ii. Three Case Records were also identified by the Examiners as examples of this practice.
- c. Neighborhood's denial letters to patients did not state the principal reason for the denial as required by RI laws and regulations.
  - i. Denial letters to the patient contain no information as to the reason for denial. Instead, the denial letter refers the patient to the prescriber denial letter, which provides some information but asks the prescriber to contact Neighborhood for a copy of the actual criteria used in making the denial.
  - ii. In one Case Record a patient currently stable on Latuda for bipolar depression was denied coverage for a refill of Latuda, even though the patient was stable on Latuda, and had unsuccessfully tried the other FDA approved medication for bipolar depression. The patient denial letter

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merely informs the patient that the prescription could not be filled and refers the patient to the denial letter to the prescriber, which is stated to be enclosed. The prescriber denial letter states that the prescription approval request was denied because Latuda is not a preferred drug in Neighborhood's formulary, and the prescriber had not demonstrated unsuccessful trials of two or more alternative medications. Nowhere in either letter does Neighborhood address the specific continuity of care issue raised by the prescriber.

- iii. Most Case Records reviewed by the Examiners demonstrated this practice.
- d. None of Neighborhood's prescriber denial letters reviewed by the Examiners include information concerning the prescriber's appeal rights, as required by RI laws and regulations.
- e. All of Neighborhood's denial letters reviewed by the Examiners require the patient to authorize in writing the prescriber to appeal the denial and this practice is not in compliance with RI laws and regulations.
- f. Several of the denial letters reviewed by the Examiners incorrectly inform patients that an appeal of the denial can be made by requesting a fair hearing before the RI Executive Office of Health and Human Services and this practice is not compliant with RI laws and regulations.
- g. Neighborhood did not gather sufficient information necessary to make an appropriate and safe utilization review decision, either in its fax forms or by outreach with the prescriber, as required by RI laws and regulations.
  - i. In most cases reviewed by the Examiners, Neighborhood's fax forms (i) did not ask the prescriber whether the request is urgent, (ii) did not ask whether the patient is being treated currently with the medication, and (iii) did not contain all the criteria needed to obtain authorization for the particular drug.
  - ii. In one Case Record the prescriber requested approval of a medication for a patient with an uncommon behavioral health condition. The prescriber noted that there was no generic or formulary medication approved for the patient's particular condition. Neighborhood denied the



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- request for coverage without attempting to communicate with the prescriber concerning the unusual situation.
- iii. In one Case Record Neighborhood denied a request for coverage of Fluoxetine in tablet form, rather than capsule form, without notifying the prescriber that a justification for the tablet form was needed and without asking the prescriber why the tablet form was needed.
  - iv. Six additional Case Records were identified by the Examiners to demonstrate this pattern of practice.
- h. Neighborhood did not adequately consider the patient's welfare and safety as required by RI laws and regulations.
- i. Neighborhood denies requests for approval of medications even though the patient has been taking the medication and is currently stable on the medication. The Examiners identified eight Case Records to demonstrate this pattern of practice.
- i. Neighborhood did not adequately consider the patient's need for continuity of care as required by RI laws and regulations.
- i. When information is provided that the patient is currently stable on the medication prescribed and requested, this fact is generally not considered by the Neighborhood medical reviewers before denying the request.
  - ii. In one Case Record the prescriber noted in the fax form request that the patient had begun taking the medication requested two months prior to the request. Neighborhood denied the request for coverage without any consideration of the patient's need for continuity of care.
  - iii. The Examiners identified ten additional denial Case Records to demonstrate this pattern of practice.
- j. Neighborhood does not fully consider all of the information provided by the prescriber, either on the fax form request or otherwise as required by RI laws and regulations
- i. In all Case Records reviewed by the Examiners, the medical reviewer does not fully state what prescriber information was obtained and/or considered when making the coverage decision.
  - ii. In one Case Record the prescriber stated on the fax form request that no generic or formulary medication was approved for the patient's condition,

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and that the medication was being prescribed because of its safe side effect profile. Nowhere in the Case record is there any indication that Neighborhood considered the prescriber's rationale for the requested medication.

- iii. The Examiners identified fourteen additional denial Case Records to demonstrate this pattern of practice.
- k. Neighborhood denies requests without making a thorough and independent review by a physician of the same licensure as the prescriber as required by RI laws and regulations.
  - i. In all prescription drug Case Records reviewed by the Examiners, pharmacy technicians and/or clinical pharmacists logged in the text for denials of coverage, and the Medical Director reviewed the denial rationale written by the pharmacy technician and/or the clinical pharmacists. In these case files, there is the absence of sufficient documentation that the physician reviewer made his/her denial decision through an independent review outside these previously documented staff/pharmacist reviews and decisions.
  - ii. A standard note in Case Records reviewed by the Examiners states "Medical director confirmed recommendation of Denial". This type of note suggests, and the Examiners so find, that the Neighborhood medical reviewer does not make a thorough, independent review of the case.
  - iii. In all Case Records reviewed by the Examiners, when additional information is noted in the Case Record by pharmacy technician and/or clinical pharmacists, the additional information is not referenced or identified by the medical reviewer.
  - iv. In one Case Record Neighborhood's pharmacist reviewed the prescriber's request, measured the request against Neighborhood's P&T Committee standards, and made a decision. While the pharmacist's decision is identified as a "recommended" decision, the Case Record demonstrated that it was the pharmacist that made the actual decision, and the medical reviewer documentation confirmed a decision already made by the pharmacist.



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I. In those cases where non-compliant utilization review practices occurred, as described in Paras. a through k, above, Neighborhood impeded or delayed care, which is also not compliant with RI laws and regulations.

- i. In one Case Record, the prescriber made an urgent request for Suboxone for a patient with opioid addiction. The approval was not made and communicated until 3 days later, putting the patient at risk of relapse, serious harm, or death.
- ii. The Examiners identified two additional denial Case Records to demonstrate this practice.

23. Inadequate documentation.

- a. Neighborhood did not adequately document the utilization review process, and utilization review decisions as required by RI laws and regulations.
- b. Case Records do not accurately document the prescriber's request, the dates and times of events in the utilization review process, peer to peer reviews and communications, and the substance of provider communications. The following are examples.
  - i. In all but a handful of Case Records where the notes indicate that there is a request for information, or a contact with the prescriber, the Case Record does not document the information received or detail the substance of the provider communication. The Examiners identified seven additional denial Case Records to demonstrate this pattern of practice.
  - ii. One Case Record does not document the prescriber's supply request.
  - iii. One Case Record contains inconsistent information concerning the patient's medication history, and why the request was initially denied and thereafter approved.
  - iv. One Case Record contains information on a patient not identified as the subject matter of the Case Record.
  - v. One Case Record does not document communications and clinical information from the prescriber, as shown in the corresponding appeal record.

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- c. Case Records do not adequately document what information was reviewed by physician reviewers, and do not adequately document the substance of conversations with prescribers. The following are examples.
  - i. One Case Record indicates that communications with the prescriber took place but does not indicate the substance of the "new information" offered by the prescriber.
  - ii. One Case Record does not document when conversations with the prescriber took place or provide adequate detail concerning the substance of the conversations.

Prescription drugs - recommendations.

24. Neighborhood shall implement the following Recommendations in order to remediate the violations described in Paras. 20 through 23, above. On or before June 1, 2020, Neighborhood 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 Neighborhood should file a final Plan of Correction, approved by the Commissioner, to implement each of the following Recommendations.

25. Neighborhood shall establish revised prescription drug utilization review criteria and policies and procedures for medications typically prescribed for behavioral health conditions in the manner set forth in (a) through (f), below.

- a. Neighborhood shall develop formal prescription drug prior authorization criteria in accordance with the laws and regulations governing commercial health insurance companies.
- b. The utilization review criteria shall include a 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 patient's specific clinical condition or circumstances. The UR Agent physician reviewer shall consider, address, and document all information submitted by the prescriber in connection with the formulary and non-formulary request. Such decisions shall be considered medical necessity decisions consistent with RIGL § 27-18.9.
- c. The "trial" period for step therapy criteria shall be based on consensus, shall be evidence-based, and shall permit the prescriber to determine, based on the prescriber's clinical observations, whether an exception to the trial period shall be granted if the patient is not responding appropriately to the alternative



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medication, or if the patient has adverse consequences to the alternative medication. Neighborhood shall propose in its Plan of Correction trial periods consistent with the above principles.

- d. Step therapy or "fail first" procedures shall not be applied without fully considering and addressing the need for continuity and transition of care, and requests for approval of a medication (or for a quantity, supply, or dose of a medication) shall not be denied, if the patient is being treated successfully with the medication requested (or is being treated successfully at the requested quantity, supply or dose of the medication) or if the prescription is being renewed. Neighborhood shall include in its Plan of Correction policies and procedures satisfactory to the Commissioner to address the patient's need for continuity and transition of care when: (1) the patient has been prescribed the medication as a member of a different health plan and/or formulary, issued by Neighborhood, (2) the patient has been prescribed the medication as a member of a health plan issued by a different carrier, (3) the patient has been prescribed a medication that is no longer on the formulary due to a NHP issued formulary change, and (4) the patient has been prescribed medication using samples supplied to the prescriber by a pharmaceutical company. For scenario # 4 herein, the Plan will implement a transition fill program that allows the member to remain on the prescribed sample medication for a period of time before converting to a formulary alternative, when clinically appropriate and provided the welfare and safety of the patient is ensured.
- e. Neighborhood shall revise its utilization review criteria for Vyvanse, Latuda, and Duloxetine to address the concerns raised in Paras. 20(d), (e), and (f).
- f. The process for soliciting comments from Rhode Island behavioral health providers concerning utilization review criteria shall be revised to improve the comment process in order to increase transparency. The process shall require NHP to fully consider all objections, comments and recommendations concerning the criteria. The process shall include implementation of the rules and regulations promulgated pursuant to R.I Gen. Laws § 27-18.9.

26. Neighborhood shall establish revised prescription drug utilization policies and procedures for medications typically prescribed for behavioral health conditions, as set forth in (a) through (m), below. Each revised policy and procedure shall be subject to an explicit

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component of a utilization review program training manual. Compliance with the policies and procedures shall be monitored by an oversight policy, conducted by Neighborhood.

- a. Neighborhood shall classify as a denial any utilization review decision that does not authorize the prescription drug requested, or does not authorize the quantity, supply, or dose of the prescription drug.
- b. Neighborhood shall ensure that the steps required for the denial and appeal process are complied with.
- c. Neighborhood shall gather, either by fax form or by communications with the prescriber, sufficient information necessary to make a clinically appropriate and safe decision. If the facts and circumstances presented suggest reason to believe that necessary clinical information critical to the utilization review decision is missing, such clinical information shall be actively solicited from the provider and Neighborhood shall allow the prescriber a reasonable period of time to respond. Fax forms and telephone protocols shall conform to the following requirements:
  - i. The protocols shall incorporate all of the specific criteria for the prescription drug requested and shall solicit the specific information needed to meet the criteria for that prescription drug.
  - ii. The request forms and protocols shall reflect a coordinated and efficient process to address all types of utilization review, including prior authorization, step therapy, or quantity limits that does not lend itself to delays in access to medically necessary medications.
  - iii. The request forms and protocols shall expressly ask the prescriber whether the request is urgent.
  - iv. The request forms and protocols shall expressly ask the prescriber whether the request is for continuation therapy. Neighborhood shall not deny the medication until it has determined after documented reasonable attempts to by the plan to consult with the prescriber, that the patient can be safely and effectively transitioned to another covered medication.
  - v. The request forms and protocols shall ensure that the necessary information is requested from the prescriber to substantiate the need for continued therapy and a process for safe transitions to alternative therapies when appropriate.



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- d. If the facts and circumstances presented in the prescriber's request suggest reason to believe that clinical information critical to the utilization review decision is missing, Neighborhood shall actively solicit the information from the provider and allow a reasonable period of time for the provider to respond.
- e. When prior approval for medication is being requested for a patient who is being discharged from a hospital, Neighborhood shall solicit information concerning medications prescribed to the patient during the hospitalization.
- f. Step therapy or "fail first" criteria shall not be applied until Neighborhood has processed the prescriber's request according to 26(c)(i-v) above.
- g. Neighborhood shall explicitly consider all information suggesting that the approval request (for a particular prescription drug, or for a quantity, supply of dose of the prescription drug) is for continuation therapy.
- h. The utilization review process shall explicitly consider whether or not a potential utilization review denial might impede care, delay care, fail to ensure continuity of care, or lead to an inappropriate transition of care.
- i. Prior to making denial and appeal decisions, Neighborhood's physician reviewers shall conduct a thorough, independent review of the prescriber's request. Neighborhood's 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.
- j. Neighborhood shall clearly state the principal reason for denial of the request, including the specific criteria not met, and the facts used to determine that the specific criteria were not met.
- k. Neighborhood's denial letters to prescribers shall provide notice of the prescriber's appeal rights.
- l. Neighborhood shall not require the patient to sign a written statement authorizing the prescriber to appeal a denial.
- m. Neighborhood shall ensure that patients and prescribers are correctly notified of their appeal rights under RI's utilization review laws and regulations.

27. Neighborhood shall establish a revised documentation policy for utilization review records ("Case Records") for prescription drugs used to treat behavioral health conditions. The revised documentation policy shall include the following requirements. Compliance with the Case Record documentation policy shall be subject to an explicit component of a utilization

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review program training manual and training module. Compliance with the policy shall be monitored by an oversight policy, conducted by Neighborhood.

- a. Case Records shall include:
  - i. The specifics of the initial prescriber request, including the rationale for the prescriber's request.
  - ii. The quantity, supply or dose of the medication requested.
  - iii. Any voluntary agreement to modify the request.
  - iv. All information submitted by the prescriber in connection with the request, including the complete, unabridged rationale for the provider's request.
  - v. All information suggesting that the request is for continuation therapy.
  - vi. The date, time and detail of each event in the utilization review process.
- b. Case Records shall document all conversations or other communications with the prescriber, including the date, time and content of the communications.
- c. Neighborhood's medical reviewer shall include documentation of all material clinical information reviewed, the utilization review criteria not met, and the reviewer's rationale for rejecting or disagreeing with the requesting prescriber's request, clinical judgment or recommendation.
- d. If a request is pended for insufficient information, the Case Record shall document (1) what specific information is needed, (2) communications with the provider, and (3) the provider's response to the communication.
- e. Case Records shall be collected, organized and maintained in a in a form and in a manner such that the Commissioner can readily ascertain compliance with state and federal laws and regulations, and implementation of these recommendations.

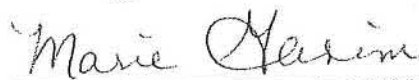


**In re Examination of Health Insurance Carrier Compliance with Mental Health  
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Wherefore, it is hereby ORDERED:

- A. The Commissioner hereby adopts the Examination Report and Recommendations.
- B. On or before June 1, 2020, Neighborhood shall file a proposed Plan of Correction to implement the recommendations set forth in this Report, for the Commissioner's consideration.
- C. On or before July 1, 2020 Neighborhood shall file a final Plan of Correction, approved by the Commissioner, to implement the recommendations set forth in this Report. Neighborhood shall implement the Plan of Correction within the time frames set forth in the approved Plan of Correction.
- D. In lieu of a penalty, Neighborhood shall make a behavioral health system infrastructure payment of \$330,000.00, payable in the amount of \$110,000 each year over three (3) years beginning no later March 31, 2020. The payments shall be made to a non-profit Rhode Island organization agreed to by the Commissioner, under terms agreed to by the Commissioner. Payments 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 Neighborhood's costs of implementing this Report's Recommendations and Orders.
- E. Within 30 days of the issuance of this Order, Neighborhood shall file with the Commissioner affidavits executed by each Director of Neighborhood stating under oath that they have received a copy of the adopted Report and related Orders.
- F. The Commissioner shall retain jurisdiction over this matter to take such further actions, and issue any supplemental orders deemed necessary and appropriate to address the Report's findings, and to implement the Report's recommendations, and orders. Such further actions may include but not be limited to validation studies conducted by the Office to verify compliance with these Orders. Neighborhood shall pay the costs of any such further actions or supplemental orders.

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



Marie Ganim, Commissioner

**In re Examination of Health Insurance Carrier Compliance with Mental Health  
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**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 Neighborhood Health Plan of Rhode Island**

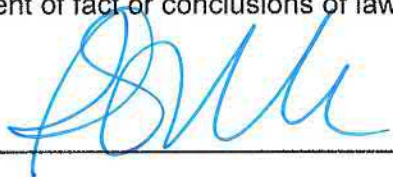
I. Neighborhood understands and agrees that this Order constitutes valid obligations of Neighborhood, legally enforceable by the Commissioner.

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

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

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

By: \_\_\_\_\_



Date: \_\_\_\_\_

2/27/2020

Title: \_\_\_\_\_

President & CEO



February 28, 2020

Marie Ganim, PhD  
Health Insurance Commissioner  
Office of the Health Insurance Commissioner  
1511 Pontiac Ave., Bldg #69, 1<sup>st</sup> Floor  
Cranston, RI 02920

Re: Neighborhood Health Plan of Rhode Island; Examination of Health Insurance Carrier  
Compliance With Mental Health and Substance Abuse Disorder Laws and Regulations (OHIC-  
2014-3)

Dear Commissioner Ganim:

Neighborhood Health Plan of Rhode Island (“Neighborhood”) appreciates the opportunity to offer a written response to the above referenced Examination (the “Report”).

The Examination began on January 8, 2015 with a Warrant of Examination issued by the Office of the Health Insurance Commissioner (OHIC). Neighborhood first offered commercial insurance on the Rhode Island Exchange in 2014, the same year as the original Examination period. While Neighborhood was a new carrier in the Rhode Island commercial market during the period reviewed, we have confidence that our practices were not only consistent with both federal and State laws, but that we offered greater access to care and removed barriers to behavioral health services upon entrance.

Neighborhood recognizes the critical nature of the findings and recommendations as contained in the Report, however, we strongly believe that at all times during the Examination period our policies and procedures were in compliance with both Rhode Island and federal laws, and we deny any wrongdoing or violation of law.

Neighborhood has been at the forefront of behavioral health care innovations, leading initiatives to improve access for members. Neighborhood has consistently offered on the Rhode Island Exchange, the most affordable, comprehensive health care plans for Rhode Islanders, with rates over 20% less than more expensive competitors. Since 2014, Neighborhood plans have encouraged the use of behavioral health services by offering services on par with primary care providers for access and cost. In 2019, OHIC required all other health plans to treat behavioral health services at the primary care level, thus lowering cost share for members.

Neighborhood has also proactively identified potential cost barriers for members; qualifying methadone maintenance and Medication Assisted Treatments (MATs) as preventive care with no cost share for members. Neighborhood has also been at the forefront of the war against opioids by removing the prior authorization requirement for Suboxone and removing ‘fail first’ criteria for Vivitrol. Two years after Neighborhood made this change, the State required all carriers to remove prior authorization requirements for such treatments.

Neighborhood recognizes that improvements must continue to foster expanded behavioral health continuums of care for Rhode Islanders. We look forward to continuing to lead by example, finding ways to offer improved access and care by working with the General Assembly, Governor Raimondo, and Rhode Island's Community Health Centers, the Health Insurance Commissioner, and other State leaders. Neighborhood will diligently work on recommendations made under this Report, as well as incorporating new initiatives to strengthen behavioral health systems of care, supporting integration with other providers.

Sincerely,

A handwritten signature in blue ink, appearing to read 'P. Marino', with a long horizontal flourish extending to the right.

Peter M. Marino  
President and CEO  
Neighborhood Health Plan of Rhode Island