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

Examination Report of Blue Cross Blue Shield of Rhode Island, in accordance with R.I.G.L. § 27-13.1-5(b).

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

August 2, 2018

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 use disorders by all four major health insurance carriers in Rhode Island. This Examination Report addresses compliance by Blue Cross Blue Shield of Rhode Island. Other Examination Reports address compliance by the other carriers.

The examination was conducted by Linda Johnson, OHIC Operations Director, and Herbert W. Olson, Esq. (former OHIC General Counsel), with the assistance of staff of the RI Office of the Health Insurance Commissioner, and the RI Executive Office of Health and Human Services, 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 has deemed appropriate.

Linda Johnson, Operations Director
RI Office of the Health Insurance Commissioner

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

Herbert W. Olson, Esq.
Hillsboro Mountain PLC

On this 7th day of August, 2018, 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 ____ day of _____, 20__, 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

August 1, 2018

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 use disorders by all four major health insurance carriers in Rhode Island. This Examination Report addresses compliance by Blue Cross Blue Shield of Rhode Island. Other Examination Reports address compliance by the other carriers.

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_____

Linda Johnson, Operations Director
RI Office of the Health Insurance Commissioner

Herbert W. Olson, Esq.
Hillsboro Mountain PLC

On this 3 day of _____, 20__, 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 31st day of July, 2018 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

DEBBIE RIGGS
Notary Public of RI
ID# 757854
My commission expires
May 1, 2019

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"), Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively "Tufts"), and UnitedHealthcare Insurance Company and UnitedHealthcare of New England, Inc. (collectively "United") (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 Blue Cross. Other Examination Reports 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, with particular focus on what are referred to as "non-quantitative treatment limitations" ("NQTL's"). NQTL's include important features of any health insurance plans, including but not limited to utilization review procedures, network adequacy, and provider reimbursement. The second targeted area of regulatory compliance for the Examination has been utilization review policies, procedures, and their implementation.

The Examination initially targeted Carrier records and operations during the 2014 calendar year period; however, where necessary because of limited numbers of records available for review in connection with some Carriers, the Examination also included a review of records and operations during 2015 and 2016.

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

2. Applicable statutes and regulations

   a. Carriers must use clinically appropriate utilization review criteria. Carriers are obligated to provide coverage for members with behavioral health conditions by virtue of their obligation to comply with their approved health benefit plan forms. RIGL §§ 27-18-8, 27-19-7.2, 27-20-6.2, and 27-41-29.2. The approved health benefit plans of Blue Cross promise to cover behavioral health services, including a continuum of care for members with mental health and substance abuse disorder 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 § 27-9-4-(3) and (4) (the Unfair Claims Settlement Practices Act). In order to fulfill those obligations, the Carrier must use clinically appropriate criteria when making its utilization review determinations. If inappropriate clinical criteria were used, the utilization review process would be neither fair nor equitable, and would not use reasonable standards in making claims determinations. Instead, the Carrier would be acting in an arbitrary manner to deny coverage for behavioral health services that are otherwise required by law to be covered.

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

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

b. Carriers must apply their utilization review criteria in a clinically appropriate manner. Based upon the statutory analysis set forth in Para. 3(a), above, 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. RIGL section 27-9-4(3) and (4) (the 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. Carriers 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)(3). 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 Examiners observe that the DOH Utilization Review Regulation and the RI Department of Health Regulation R23-17.13 (DOH Health Plan Certification Regulation) prohibits many practices which also constitute violations of the Unfair Claims Settlement Practices Act. Thus, Carriers' obligation to establish reasonable utilization review standards, and to act in a prompt, fair, and equitable manner in acting upon requests for approval of coverage for behavioral health services is independently grounded in both Title 27, RIGL, and in RI Department of Health Regulations.

d. Carriers must provide coverage of benefits and services without unreasonable delay and without impeding care. A Carrier must provide coverage of benefits described and promised in a member's health benefit plan. RIGL §§ 27-18-8, 27-19-7.2, 27-20-6.2, and 27-41-29.2. Coverage must be provided in a reasonably prompt manner. RIGL § 27-9.1-4(3). The Examiners observe that 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 and network adequacy. 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 its state insurance laws, including laws and regulations within Title 27, and health insurance laws and regulations authorized under Title 23.

f. Mental health and substance use disorder coverage must be provided at parity with medical-surgical coverage. State law requires parity in coverage for mental health and substance use conditions with medical-surgical conditions. Rhode Island's parity law was originally enacted in 1994, and amended in 2014 to reflect the federal behavioral health parity law enacted in 2008, and to reflect final federal regulations adopted in 2013. The core legal principals and parity obligations for carriers have remained the same throughout the examination period: (1) carriers must provide coverage for the treatment of mental health and substance use disorders, and (2) such coverage must be provided under the same terms and conditions as coverage is provided for other illnesses and diseases. RIGL § 27-38.2-1(a).

Federal law also requires parity in coverage for mental health and substance abuse disorder 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 pervasive manner for behavioral health services as compared to medical-surgical services, (ii) if prior authorization is required or recommended for a medically necessary continuum of care for chronic behavioral health conditions, but is not required or recommended for comparable chronic medical conditions, (iii) if prior authorization is applied in a more stringent manner to behavioral health conditions than for medical-surgical conditions, and (v) if benefit plan exclusions apply exclusively to behavioral health conditions or services. 45 C.R.F. § 146.136(c)(4)(examples 9 and 10).

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, OHIC Operations Director, Herbert W. Olson, Esq. (former OHIC General Counsel), Jack Broccoli, Chief Insurance Financial Examiner, RI Department of Business Regulation, and Charles DeWeese, OHIC actuary, as Examiners. Linda Johnson and Herbert Olson were in charge of the Examination. Linda Johnson can be reached at Linda.Johnson@ohic.ri.gov. Herbert Olson can be reached at herb.olson123@gmail.com. Assisting the Examiners were the following OHIC staff: Emily Maranjian, OHIC Legal Counsel, John Garrett, Health Reform Specialist, Cheryl Del Pico, Special Projects Coordinator, Victor Woods, Health Economics Specialist, Alyssa Metivier, Health Economics Specialist, and James Lucht, RI EOHHS Deputy Director of Analytics.

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

c. The Examiners requested and received from the Carriers case records of utilization review decisions (Case Records). Case Records are an important feature of the Examination, because they permit the Examiners to measure the actual implementation of a Carrier's policies and procedures against their legal obligations relating to utilization review and parity. The Examiners reviewed the Case Records for compliance with procedural or non-clinical requirements. The Examiners also identified Case Records which needed review by behavioral health clinicians in order to evaluate the clinical appropriateness of Carrier utilization review criteria, utilization review decisions, and other matters requiring clinical judgment.

d. In accordance with the Examination Act, the Examiners retained expert clinicians in behavioral health associated with Massachusetts General Hospital (MGH Clinicians), under the direction of Ronald Schouten, MD, JD, Director, Law and Psychiatry Service. The Examiners listed the clinical issues to be reviewed by the MGH Clinicians, and 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. The Examiners' data sampling methodology was developed by James Lucht, RI EOHHS Deputy Director of Analytics, in consultation with the Insurance Division of the RI Department of Business Regulation. The essential elements of the sampling methodology is described below:

> In order to produce a random representative sample of cases for examination, a Random Stratified Sample with Proportional Distribution was used. For behavioral health claims, the main factors were disposition (approved vs. denied), client age, diagnosis, and setting. For prescription drug claims the main factors were disposition, diagnosis, and drug type. Basic steps are as follows:
>
> 1. Create aggregate columns for diagnosis, age, setting, and drug type to lessen the number of unique sampling categories. See appendix for specifics on how each column was grouped. Also add Random and Sample columns.
> 2. Create pivot table that counts each unique combination of categories for approvals and denials.
> 3. Determine sample size for approvals and denials.
> 4. Using the pivot table, determine percentage of approval and denials in each unique combination category. Multiply this

percentage by the sample size. Results with a value less than one were rounded up to one. If key categories of interest have very low numbers (<3) add one or more cases (oversampling).
5. Sort by Date of Service
6. Generate random number column in Excel using RAND function.
7. Sort by key categories (Setting, Simplified Dx, Age Category) and random number.
8. Choose the specified number of cases from each category starting from the top of each grouping in the spreadsheet, mark new Sample column with a 1.
9. Filter on Sample =1 and copy/paste into new sheet.
10. Pare down number of columns to just the number needed for the carrier to identify the case.

The biggest challenge was to get a representative sample among smaller case groupings. For example, juvenile cases and some combinations of diagnoses and settings are so few that we can't hope to say anything about that class of case unless we greatly oversample. To overcome this, we began with a random proportional sample, assessed classes of cases with low numbers, and then combined categories based on similarity.

f. Blue Cross was being very cooperative and professional in its responses to information requested by the Examiners. At the conclusion of the Examination, the Examiners met with Blue Cross to discuss the Examiners' proposed findings and recommendations. In response, Blue Cross offered some truly innovative and ground-breaking initiatives – such as elimination of utilization review for in-network behavioral health services - to mitigate utilization review as a potential barrier to medically necessary behavioral health services. Blue Cross also proposed major investments in infrastructure to address gaps in behavioral health service resources in Rhode Island. The Examiners acknowledge Blue Cross' positive efforts to improve coverage of behavioral health services to residents of Rhode Island.

g. 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.

Behavioral health findings

4. In accordance with the methodology described in Para. 3, above, the Examiners selected 269 BH utilization review case records relating to requests for approval of behavioral health services made on behalf of Blue Cross members. Of those 269 BH case records, 145 cases resulting in an authorization of the request were reviewed by the Examiners. Of those 145 BH authorization cases, 10 were forwarded to the MGH Clinicians for review of clinically-related issues. Of those 269 BH case records, 124 were cases resulting in denial of the request. Of those 124 BH case records, 29 were forwarded to the MGH Clinicians for review of clinically-related issues. All 269 BH case records (authorizations and denials), were reviewed by the Examiners for process-related issues.

5. During the 2014 calendar year, Blue Cross delegated administration of its utilization review program for behavioral health services to ValueOptions. Currently, Beacon Health Options, a company formed by a merger between ValueOptions and Beacon Health Strategies, administers Blue Cross' utilization review programs for behavioral health services.

6. ValueOptions administered Blue Cross' utilization review program for behavioral health services pursuant to ValueOptions policies and procedures approved by Blue Cross. Oversight of ValueOptions by Blue Cross was conducted by means of periodic reporting and joint company meetings. Despite such oversight activities, ValueOptions had significant discretion in terms of its utilization review criteria, and the day-to-day administration of the program. At all times, Blue Cross remained fully responsible for compliance with state and federal laws and regulations.

7. The Examiners find that the conduct, policies or procedures described in Paras. 8-19 constitute noncompliant patterns or practices under RIGL Title 27, Chapter 9.1 (Unfair Claims Settlement Practices Act), DOH Utilization Review Regulations, or DOH Plan Certification Regulations.

8. Blue Cross and its UR Agent used clinically inappropriate utilization review criteria for coverage of behavioral health services. For example:

a. Utilization review criteria used by Blue Cross and the company contracted with by Blue Cross, and delegated to administer its utilization review program (UR Agent) used circular reasoning in its utilization review criteria by allowing non-clinical considerations embedded in exclusion criteria and discharge criteria to supersede clinical criteria for admission or continued stay. For example, a psychotic patient displaying observable symptoms of being an active danger to self and others was found to meet criteria for admission for treatment in a residential setting, yet was denied treatment based on a generalized exclusion criterion that "the patient can be treated at a lower level of care". Two other Case Records reviewed by the Examiners demonstrate this practice.

b. Utilization review criteria used by Blue Cross and its UR Agent were not based on objective, measurable, clinical criteria. Instead, the utilization review criteria contained criteria were based on subjective, vague, and generalized conclusions or judgments. For example, a patient with an eating disorder was found to meet objective, measurable clinical criteria for admission to a residential treatment center, yet was denied coverage for treatment because, in the UR Agent's judgment, "the patient can be treated at a lower level of care".

c. Four (4) other Case Records reviewed by the Examiners demonstrate the use of vague, subjective, or circular criteria.

d. Five (5) other Case Records reviewed by the Examiners demonstrate the use of clinically inappropriate eating disorder criteria.

e. Under the utilization review criteria used by Blue Cross and its UR Agent, patients were be denied coverage for a higher level of care recommended by the treating provider without documentation by the UR Agent that the patient met clinical criteria for a lower level of care. In one case, a patient with severe psychosis admitted to in-patient care was recommended for discharge because, in the UR Agent's judgment, the patient was "stable" and could be discharged to home, notwithstanding the patient's continued paranoia and delusions

concerning the home environment. Two (2) other Case Records reviewed by the Examiners demonstrate this practice.

f. The utilization review criteria used by Blue Cross and its UR Agent allowed the denial of continued coverage if the UR Agent concluded that the patient had shown "lack of improvement" or insufficient progress", without documentation demonstrating that the clinical circumstances of the patient were taken into consideration. For example, an extremely disturbed patient who was partially adherent to prescribed anti-psychotic medications was denied continued inpatient care because the UR Agent determined that the patient was failing to make sufficient improvement, even though there were sound clinical reasons for gradually introducing a new medication regime for the patient, and notwithstanding that there may have been a clinical rational for an alternative treatment plan. Eighteen (18) additional Case Records reviewed by the Examiners demonstrate the use of "lack of improvement" or insufficient progress" in making utilization review decisions

g. The utilization review criteria used by Blue Cross and its UR Agent allowed the denial of coverage for continued treatment based on the patient's failure to participate in treatment or discharge planning, without properly considering and documenting whether the patient's clinical conditions or other factors beyond the control of the patient might be present. The criteria appeared to permit a patient to be denied coverage for treatment for a mental health condition because the mental health condition itself impaired the patient's ability to make treatment or discharge planning decisions that the UR Agent believed were rational. Four (4) Case Records reviewed by the Examiners demonstrate the use of "failure to participate" in making utilization review decisions.

9. Blue Cross and its UR Agent applied their utilization review criteria in a clinically inappropriate manner. Clinically inappropriate application of the utilization review criteria occurred when:

a. The observations, conclusions and decisions made, or the facts relied upon by the UR Agent either were not supported in the utilization review case record (Case Record), or were contradicted in the Case Record. In one case, a patient

with a significant substance use disorder, depression, suicidal ideation, and a long history of treatment, release and relapse was denied residential treatment following in-patient detoxification and stabilization. The treating provider's recommendation was rejected despite documented clinical observations that the patient continued to have suicidal thoughts with the likelihood of relapse given the non-supportive living environment. Eleven (11) Case Records were reviewed by the Examiners where the observations, conclusions and decisions made, or the facts relied upon by the UR Agent either were not supported in the Case Record, or were contradicted in the Case Record.

b. The UR Agent recommended a shorter length of stay or a lower level of care from that requested by the treating provider, without a documented clinical basis for the recommendation. For example, a UR Agent approved only 4 days of treatment for a patient with an acute eating disorder episode, notwithstanding that the patient's medical complications and the severity of her eating disorder symptoms made a longer length of stay the clinically appropriate course of treatment. Later, the UR Agent denied coverage for continued treatment and the patient was discharged to outpatient care even though the patient was still struggling with the patient's eating disorder, and the patient's home environment posed serious impediments to improvement. Thirty-three (33) Case Records reviewed by the Examiners demonstrate shorter or lower length of stay decisions without adequate clinical basis for the shorter stay of or lower level of care.
c. The UR Agent applied incorrect utilization review criteria based on the patient's specific behavioral health disorder. For example, a patient with a history of mental illness and homelessness was admitted for alcohol abuse treatment. After detoxification, the UR Agent recommended discharge to an outpatient setting, rather than recommend continued treatment to address the patient's mental condition. If the appropriate mental health criteria had been applied, coverage would have been approved for continued treatment. Five (5) Case Records reviewed by the Examiners demonstrate the use of incorrect utilization review criteria.

d. The utilization review process was used to address perceived quality of care issues with the requesting provider's treatment, thereby denying coverage for care for the patient due to the provider's failure to meet the treatment expectations of the UR Agent. Three (3) Case Records reviewed by the Examiners demonstrate this practice.

e. The requests of the treating provider were discounted or ignored even when there was no dispute as to the facts and circumstances relating to the patient's condition or treatment. For example, a patient with a history of opioid use disorder and frequent relapses was recommended for a series of sequentially lower levels of care in order to mitigate against the risk of relapse. The UR Agent denied coverage for these treatment recommendations, notwithstanding there was no factual dispute upon which the treating provider concluded that (i) the patient had a high risk of relapse, (ii) an abrupt discharge to less intensive treatment settings had a high risk of being unsuccessful, and (iii) the patient's home environment was not conducive to avoiding relapse". Twelve (12) Case Records reviewed by the Examiners demonstrate this practice.

f. Thirteen (13) additional Case Records reviewed by the Examiners demonstrate the UR Agent's failure to apply its utilization review criteria in a clinically appropriate and consistent manner.

10. Different UR Agent staff reached very different conclusions based on similar facts and clinical circumstances. Such variable decision-making creates the possibility of arbitrary and unwarranted denials of coverage and treatment. Two (2) Case Records reviewed by the Examiners demonstrate this practice.

11. Blue Cross and its UR Agent conducted frequent, short term concurrent reviews of coverage for patients' continued treatment, without an objective or clinical basis for either the frequency of the reviews or their short duration.

a. For example, a patient was hospitalized with severe and dangerous psychotic symptom requiring a lengthy in-patient stay. The patient and the treating providers were subjected to the following set of concurrent reviews and short duration approvals by the UR Agent:

Initial review for admission, 3 days requested, 3 approved.

First concurrent review, 7 days requested, 4 approved.
One day approved awaiting a UR Agent physician review.
Denial made by UR Agent physician reviewer due to disagreement with medication treatment.
Case appealed, and 4 days were approved. Documentation is unclear as to what was requested by the facility.
Concurrent review, 5 days requested, 3 approved.
Concurrent review, requested 5 days, 2 approved.
Concurrent review, 6 days requested, 6 approved.
Concurrent review, 4 days requested, 4 approved.
Concurrent review, 5 days requested, 2 approved.
Concurrent review, 5 days requested, 4 approved.
Concurrent review, 4 days requested, 2 approved.
Concurrent review, 3 days requested, 2 approved.
Concurrent review, additional coverage denied.

b. Thirty-two (32) Case Records reviewed by the Examiners demonstrate the UR Agent's practice of conducting frequent concurrent reviews, where benefits approved were frequently shorter than requested by the patient's treating provider.

12. Blue Cross and its UR Agent did not adequately document their utilization review decisions by:

a. Failing to collect and maintain adequate documentation of the patient's clinical condition. Case Records that do not contain sufficient documentation of the utilization review process and decisions, and of the patient's condition and circumstances. Seventeen (17) Case Records reviewed by the Examiners demonstrate this practice.

b. Failing to adequately document the denial rationale, including a response to the provider's rationale for the request, and the specific criteria not met in relation to the patient's clinical condition and circumstances. One (1) Case Record reviewed by the Examiners demonstrates this practice.

c. Failing to adequately document the treating provider's rationale and the clinical details supporting the request for coverage. One (1) Case Record reviewed by the Examiners demonstrates this practice.
d. Failing to adequately document a provider's agreement to a modification or reduction of the treatment request. Seven (7) Case Records reviewed by the Examiners demonstrate this practice.
e. Failing to provide adequate documentation of the rationale for "updating" its utilization review decision. One (1) Case Record reviewed by the Examiners demonstrates this practice.
f. Failing to document peer to peer communications. One (1) Case Record reviewed by the Examiners demonstrates this practice.
g. Poorly organizing its case documentation. One (1) Case Record reviewed by the Examiners demonstrates this practice.
h. Failing to adequately document events and facts relevant to the utilization review process. Sixteen (16) Case Records reviewed by the Examiners demonstrate this practice.

13. Blue Cross and its UR Agent engaged in unreasonable, and inequitable utilization review procedures by:

a. Classifying as authorizations utilization review decisions that should have been classified as denials. Nine (9) Case Records reviewed by the Examiners demonstrate this practice.
b. Attempting to fulfill the provider consultation requirement by making a single call to the treating provider and insisting on an immediate call response. One (1) Case Record reviewed by the Examiners demonstrates this practice.
c. Failing to use a physician reviewer of the same licensure status as the requesting physician. One (1) Case Record reviewed by the Examiners demonstrates this practice.
d. Inserting an extra "reconsideration" step in the utilization review process. One (1) Case Record reviewed by the Examiners demonstrates this practice.
e. Failing to follow the requirements for forwarding a case to external appeal. One (1) Case Record reviewed by the Examiners demonstrates this practice.

f. Using denial notifications that contain overly graphic language that might have an adverse impact on the patient's treatment. Nine (1) Case Records reviewed by the Examiners demonstrate this practice.

g. Using denial notifications that, if the appeal is assigned to the provider, requires the patient to relinquish appeal rights to the provider even if the provider decides to terminate the appeal process. All Case Records reviewed by the Examiners demonstrates this practice.

14. Blue Cross and its UR Agent did not properly consider patients' welfare and safety with respect to appropriate transition of care, and continuity of care. Patients could be discharged from treatment following denial of coverage, contrary to the recommendation of the treating provider, even if necessary socio-economic supports were not available. For example, in one case a patient with diagnoses of opioid dependence and other mental health and substance use disorders, and a history of behavior dangerous to self and others was recommended for residential care following hospitalization. The UR Agent determined that the patient could be treated at a lower level of care, even though the treating provider concluded the patient had nowhere to live that could support the patient's sobriety, and that therefore the patient was at a high risk of relapse. Fourteen (14) Case Records reviewed by the Examiners demonstrate this practice.

15. As a result of the patterns and practices described in Paras. 8-14, above, care was either impeded or delayed, or was potentially impeded or delayed. For example, in one case a patient diagnosed with opioid and cannabis dependence, with a long history of treatment and relapse, was recommended for a gradual series of step-down treatments from hospitalization, including residential care, partial hospitalization, and an intensive outpatient program. Instead, the UR Agent repeatedly and persistently pressured the treatment program to accept a level of care one step lower than was clinically necessary, and for fewer days than requested. Eighteen (18) Case Records reviewed by the Examiners demonstrate this practice.

16. With respect to its behavioral health parity obligations, Blue Cross applied its parity obligations by applying utilization review to a much broader scope of behavioral health services than is the case with medical surgical services. Utilization review was applied to the entire spectrum and continuum of care for patients with behavioral health conditions, excepting only out-patient behavioral health services. In contrast, utilization review of medical-surgical levels of

care was applied primarily to hospitalization, post-hospital settings, and some intensive hospital outpatient surgery and services, while some intensive procedures conducted in a doctor's office were unaffected by the utilization review process.

17. A review of Blue Cross' silver level health benefit plan issued for use in calendar year 2014 revealed coverage exclusions that were unique to behavioral health conditions or services. As a result, coverage for behavioral health services during calendar year 2014 was not "comparable to", or "subject to the same terms and conditions", as coverage for medical-surgical conditions and services. Since 2014, these improper coverage exclusions have been eliminated from Blue Cross' health benefit plans.

18. The Case Records reviewed by the MGH Clinicians and the Examiners showed that there is reason to believe that utilization review of behavioral health services is applied in a more stringent manner than is the case with medical-surgical services. In response to multiple requests by the Examiners, Blue Cross stated that parity analysis of its utilization review program in 2014 had been conducted, but the parity analysis was not provided to the Examiners. Five (5) Case Records reviewed by the Examiners demonstrate this practice.

Behavioral health recommendations.

19. Blue Cross should implement the following Recommendations in order to remediate the noncompliant patterns and practices found by the Examiners and described in Paras. 8-18. On or before September 28, 2018 Blue Cross should propose a Plan of Correction to implement each of the following behavioral health recommendations set forth in Paras. 20-23.

20. Blue Cross should revise its behavioral health utilization review criteria in the following manner:

a. Only objective, clinically-based, written criteria should be used to deny requests for behavioral health services.
b. Level of care criteria should ensure that if clinically-based admission or continued stay criteria have been met, other portions of the criteria (e.g. exclusion criteria or discharge criteria) cannot over-ride the admission or continued stay criteria.
c. Blue Cross should not deny a request for continued stay based on the rationale that the patient is showing lack of improvement, or the patient is making insufficient progress, or the patient is failing to participate in treatment

d. Utilization review criteria should not permit denial of 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. The practice of frequent, short duration concurrent reviews unrelated to the clinical condition of the patient should be prohibited. Where available, criteria should include generally accepted "estimate length of stay" components, and concurrent reviews should 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 should 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 should permit a change in the ELOS in the case of dually diagnosed patients.

f. The criteria should include an "exceptions policy" that offers providers an opportunity to request approval of a behavioral health service inconsistent with the national criteria, based on the unique or unusual nature of the patient's clinical condition or circumstances. Such decisions should be considered medical necessity decisions. The UR Agent physician reviewer should consider, address, and document all information submitted by the ordering provider in connection with the exceptions request.

g. The process for soliciting comments from Rhode Island behavioral health providers and other interested parties concerning behavioral health criteria should be amended to include mechanisms to improve the comment process in order to increase transparency and public engagement. The process should require Blue Cross to consider fully all objections, comments and recommendations concerning the revisions. Prior to the effective date of criteria adoption or revision, Blue Cross should file with the Commissioner and post a statement of the principal reasons for and against the adoption or revision, including Blue Cross' reasons for overruling the objections, comments or recommendations made by providers and other interested parties.

21. Blue Cross should establish the following revised policies and procedures for utilization review of behavioral health services. Each revised policy should be subject to an explicit component of a utilization review program training manual. Compliance with the policies should be monitored by an oversight policy, conducted by Blue Cross:

a. There should be a documented and clinically-based rationale to recommend discharge to a lower level of care prior to the estimated length of stay.
b. If the facts and circumstances presented to the UR Agent suggest reason to believe that necessary clinical information critical to the utilization review decision is missing, such clinical information should be actively solicited from the provider.
c. When the material facts and circumstances are not in dispute, the utilization review decision should not conflict with the treating provider's level of care or length of stay recommendation unless the provider's recommendation is clearly unreasonable.
d. Any decision that does not authorize the provider's request, at the level of care and for the number of days requested, should be classified as a denial, absent the provider's documented communication of agreement to modify the request. When the UR Agent suggests a modification of the request, the UR Agent should communicate and document a clinically-based rationale for the suggested modification.
e. The initial denial must be made independently, by a provider of the same licensure status as the requesting provider. Lower level UR Agent staff should not communicate any recommendations, suggestions, or comments related to disposition of the service request to the UR agent reviewing provider.
f. The utilization review process should not be used to address quality of care issues. The revised policy should describe alternative means of addressing quality of care issues observed by the UR Agent.
g. Utilization review denials of a higher level of care should include a clinically-based finding that there is a specific program at a lower level of care which is clinically appropriate and available for the patient.
h. Review agency/carrier case Managers should not be involved in the utilization review process.

i. The utilization review process should require the UR Agent to explicitly consider and document whether or not a potential utilization review denial might impede care, delay care, or lead to an inappropriate transition of care.

j. Denial notifications should avoid language that might unnecessarily adversely affect the patient, such as overly graphic descriptions of the patient's condition or circumstances, or comments concerning the provider's treatment that might undermine the provider-patient relationship.

k. Whenever a patient assigns to the provider his or her appeal rights, the utilization review program should prohibit the waiver of the patient's right to pursue a higher level of appeal if the provider declines to pursue the appeal.

22. Blue Cross should establish a revised documentation policy for utilization review records for behavioral health services that includes the following requirements. Compliance with the Case Record documentation policy should be subject to an explicit component of a utilization review program training manual. Compliance with the policy should be monitored by an oversight policy, conducted by Blue Cross:

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

b. Case Records should document in detail all conversations or other communications with the treating provider.

c. Case Records should document in detail all clinical information offered by the provider, and the complete rationale for the provider's request for approval of services.

d. Case Records should be maintained by episodes for each level of care from admission to discharge, and not solely by separate requests for approval. Case Records should also be maintained so as to identify and report such episodes. (Blue Cross has proposed a definition of "episode of care" which counts as a single episode an admission and readmission within a 30-day period.)

e. Case Records should include the actual, independently prepared review of the UR Agent's physician reviewer.

f. Case Records should include in the UR Agent's physician review documentation that all material clinical information was reviewed, and should include

documentation of the utilization review criteria not met, and documentation of the reviewer's rationale for rejecting or disagreeing with the requesting provider's clinical judgment or recommendation.

g. When the UR Agent recommends a modification of the treating provider's request, the Case Record should document a clinically-based rationale for the recommended modification.

h. The Case Record should document the treating provider's express communication of an agreement to modify the provider's request. The UR Agent's statement of the provider's agreement alone should not satisfy this documentation requirement.

i. Case Records should 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.

23. Blue Cross should revise and narrow the scope of behavioral health services subject to prior authorization. Blue Cross should 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. Blue Cross should propose for the Commissioner's approval the form and content of the utilization review parity analysis. If feasible, the analysis should be conducted in the following manner. If Blue Cross believes that some elements of the following are not feasible, Blue Cross should 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 disorder, and medical surgical benefit, (ii) state the number of requests processed for each mental health, substance use disorder, and medical surgical benefit, and (iii) state the number of denials, appeals, and denials on appeal for those requests processed for each mental health, substance use disorder, and medical surgical benefit.

b. Identify which mental health, substance use disorder, and medical surgical benefits (excluding prescription drug benefits) were not subject to utilization

review, and state the number of claims processed for each mental health, substance use disorder, and medical surgical benefit.

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

d. For each mental health, substance use disorder, and medical surgical benefit subject to utilization review identified in Paras. 20.a, above, propose a methodology for determining whether utilization review for mental health and substance use disorder benefits are applied no more stringently than utilization review applied to medication surgical benefits. Such a methodology should: (i) use actual utilization review case records in comparing the degree of stringentness, (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 (iv) consider any other appropriate factors in determining the comparable rigorousness of the reviews.

Prescription drug findings

24. In accordance with the examination methodology described in Para. 3, above, the Examiners selected 175 RX utilization review case records, of which 93 were classified as authorizations and 82 RX utilization review case records which were classified as denials relating to requests for approval of prescription drugs for behavioral health conditions. Of those 175 RX case records, 5 cases classified as authorizations and 18 cases classified as denial records were forwarded to the MGH Clinicians for review of clinically-related issues. Of those 175 RX case records, 93 RX case records classified as authorizations and 82 RX case records classified as denials were reviewed by the Examiners for process-related issues.

25. During the 2014 calendar year, Blue Cross delegated administration of its utilization review program for prescription drugs to a UR Agent, the pharmacy benefit management firm Catamaran. Subsequently, Catamaran was acquired by OptumRX, a subsidiary of United

Healthcare Group, and Blue Cross delegated administration of its utilization review program for prescription drugs to OptumRX.

26. Catamaran administered Blue Cross' utilization review program for prescription drugs pursuant to criteria proposed by Catamaran and approved by Blue Cross, and administered in accordance with Catamaran policies and procedures approved by Blue Cross. Oversight of Catamaran by Blue Cross was conducted by means of periodic reporting and joint company meetings. Despite such oversight activities, Catamaran had significant discretion in terms of its utilization review criteria, and the day-to-day administration of the program. Blue Cross remained fully responsible for compliance with state and federal laws and regulations.

27. The Examiners find that the conduct, policies or procedures described in Paras. 28-35 constitute noncompliant patterns or practices under RIGL Title 27, Chapter 9.1 (Unfair Claims Settlement Practices Act), DOH Utilization Review Regulations, or DOH Plan Certification Regulations.

28. The prior authorization criteria for several prescription drugs used to treat behavioral health conditions were clinically inappropriate; for example, based on the MGH Clinicians observations and conclusions, as set forth in the Report's confidential Working Papers:

a. Medication assisted treatment.
    i. The use of prior authorization for medication assisted treatment of opioid dependence disorders is clinically inappropriate.
    ii. The opioid crisis facing Rhode Island and many other states demands, and has demanded for many years, an urgency by health care providers and health insurance companies that has not always been reflected in their response to the emergency. 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 the negative impact on public health from failing to treated opioid dependent patients without delay.
    iii. The Examiners appreciate the willingness of Blue Cross and the other Carriers to collaborate with the Office during the spring of 2017 to eliminate prior authorization requirements for medication-assisted treatment.

b. The requirement of a lengthy trial of an alternative medication, for example 60 days, was excessive for some medications because a clinical determination can be made in a shorter length of time of whether or not the alternative medication is effective.
c. Some prescription drugs are so much more effective than alternatives that the requirement for two or more trials of alternative medications, and the resulting delay in providing a potentially more effective treatment, is unreasonable.
d. When certain medications are used as an adjunctive therapy for patients who do not reach full remission, the prior authorization requirement of multiple alternative trials is clinically inappropriate.
e. For certain drugs already prescribed to patients in an inpatient setting, the utilization review requirement for trials of alternatives may be unreasonable, may improperly impede or delay treatment, and may result in a longer hospital stay than necessary.
f. The prior authorization criteria for certain drugs fail to allow exceptions for special populations.
g. Prior authorization criteria fail to include an opportunity for the provider to support a clinically-based exception to the criteria, given the particular patient's condition and treatment needs. Three (3) Case Records reviewed by the Examiners demonstrate this practice.
h. Suitable alternative medications were sometimes considered insufficient with respect to trial and fail requirements.
i. Fail first criteria for certain drugs used to treat musculoskeletal pain should not suggest the use of potentially addictive drugs opioids as trial alternative medications.
j. Prior authorization requirements were imposed even if the patient has been successfully treated in the past on the drug. Two (2) Case Records reviewed by the Examiners demonstrate this practice.
k. Prior authorization criteria that incorporate and require adherence to FDA guidelines can fail to permit access to off-label, but clinically appropriate, use of prescription drugs. FDA guidelines were used to deny a prescription drug

request, rather than addressing the patient's actual clinical circumstances. Use of FDA guidelines occurred even if the guidelines were not included in the prior authorization criteria or the prior authorization fax form. Nineteen (1) Case Records reviewed by the Examiners demonstrate this practice.

29. Prior authorization criteria were applied in a clinically inappropriate manner when:
    a. Incorrect facts were used in denying the request. One (1) Case Record reviewed by the Examiners demonstrates this practice.
    b. There was reason to believe that critical clinical information is missing, but the UR Agent did not solicit the information from the provider, or did not make reasonable attempts to obtain the necessary information. Four (4) Case Records reviewed by the Examiners demonstrate this practice.
    c. Despite a claims history of the patient having been tried on three alternative medications, the UR Agent did not communicate with the prescriber to ascertain whether the UR Agent's fail first criteria had been met. One (1) Case Record reviewed by the Examiners demonstrates this practice.
    d. Inconsistent decisions were made in different cases involving similar circumstances. One (1) Case Record reviewed by the Examiners demonstrates this practice.
    e. The UR Agent denied a request even though the information shows that the request met the UR Agent's prior authorization criteria. One (1) Case Records reviewed by the Examiners demonstrates this practice.
    f. The UR Agent denied a request using incorrect criteria. One (1) Case Records reviewed by the Examiners demonstrates this practice.
    g. The utilization review process did not allow an adequate opportunity for the prescriber to request an exception to the prior authorization criteria based on the unique clinical circumstances of the patient. For example, the UR Agent denied a requested medication despite the prescriber's explanation that the patient could not try alternatives because of the patient's unrelated medical disorder. One (1) Case Records reviewed by the Examiners demonstrates this practice.
    h. The utilization review process improperly applied fail first criteria, and did not adequately consider continuity of care and transitions of care when requests

were denied for patients already being treated with the prescription drug. For example, when presented with a patient who had been hospitalized for a lengthy period of time, the UR Agent did not adequately consider or investigate whether the patient most likely had been prescribed the requested medication during the lengthy hospitalization. Eleven (11) Case Records reviewed by the Examiners demonstrate that the UR Agent failed to adequately consider the patient's need for continuity of care and transitions of care.

i. Twenty-two (22) additional Case Records reviewed by the Examiners demonstrate improper application of fail first criteria.

j. Three (3) additional Case Records reviewed by the Examiners demonstrate the UR Agent's failure to apply its utilization review criteria in a clinically appropriate manner.

k. The UR Agent did not adequately consider all of the information offered by the prescriber in support of the prior authorization request. Two (2) Case Records reviewed by the Examiners demonstrate this practice.

l. The UR Agent relied solely on the existence of an opioid claim in the claims system to deny coverage for opioid addiction treatment, without seeking clarification as to whether the patient had actually used the previously prescribed opioid medication. Two (2) Case Records reviewed by the Examiners demonstrate this practice of relying on claim records without outreach to the prescriber.

30. Blue Cross and its UR Agent used outdated or otherwise improper authorization fax forms. For example:

a. The use of a "wrong" fax form may have influenced an incorrect utilization review decision, even if all necessary information was provided on the form. Two (2) Case Records reviewed by the Examiners demonstrate this practice.

b. Fax forms did not provide notice to the provider of information needed in order to avoid a prior authorization denial. Two (2) Case Records reviewed by the Examiners demonstrate this practice.

c. The fax form did not include a list of all approved diagnoses. One (1) Case Records reviewed by the Examiners demonstrates this practice.

d. Multiple fax forms remained in use, with different information solicited on different forms. As a result, prescribers understandably could be confused as what is needed to obtain approval for a requested medication. Three (3) Case Records reviewed by the Examiners demonstrate this practice.
e. Twenty-three (23) additional Case Records reviewed by the Examiners demonstrate the improper use of fax forms.

31. Blue Cross and its UR Agent did not conform to required utilization review procedures by, for example:

a. Using improper procedures for pending and denying requests, and for appeals. Fifteen (15) Case Records reviewed by the Examiners demonstrate this practice.
b. Instead of making an independent clinical decision on a prior authorization request, the UR Agent's physician reviewer simply "upheld" the decision of non-physician staff of the UR Agent. Thirteen (13) Case Records reviewed by the Examiners demonstrate this practice.
c. Unreasonably delaying prior authorization decisions. One (1) Case Records reviewed by the Examiners demonstrates this practice.
d. When a case was pended for insufficient information, not notifying or seeking clarification from the prescriber concerning what specific information is needed. One (1) Case Records reviewed by the Examiners demonstrates this practice.
e. Not making reasonable attempts to communicate with the prescriber. One (1) Case Records reviewed by the Examiners demonstrates this practice.
f. Not issuing a denial notification in a timely manner. One (1) Case Records reviewed by the Examiners demonstrates this practice.
g. Improperly classifying denials as authorizations.
    i. Twelve (12) Case Records reviewed by the Examiners demonstrate that the UR Agent classified cases sent to the Examiners as authorizations but which in fact were denials.
    ii. Five (5) Case Records reviewed by the Examiners demonstrate the practices of classifying cases as authorizations but the quantity of a prescription drug requested by the treating provider was denied by the UR Agent (even though a lower quantity was authorized).

h. Forty-eight (48) Case Records reviewed by the Examiners demonstrate the practice of poor communications with the prescriber, or poor documentation of communications with the prescriber.

32. Blue Cross and its UR Agent did not adequately document its utilization review decisions by:

a. Failing to document events of the prior authorization process correctly.
b. Failing to clearly document the basis for a denial.
c. When requests are pended for insufficient information, failing to document what specific information was needed.
d. Failing to document the UR Agent's consideration of the clinical information and rationale supporting the prescriber's request.
e. Failing to adequately document communications between the UR Agent and the prescriber.
f. Failing to adequately document the decision of the UR Agent's physician reviewer, and to document that the physician reviewer (rather than other UR Agent staff) made the decision.

33. A provider's request for prior authorization was subject to multiple utilization review processes when a request for a drug at a particular drug dose or supply is made, but the UR Agent required that separate reviews be conducted for supply limits and dose limits.

34. As a result of the patterns and practices described in Paras. 28-33, above, care was either impeded or delayed, or was potentially impeded or delayed. For example:

a. A patient was prescribed Suboxone at a dose of 24 mg per day to treat the patient's opioid dependence. The UR Agent denied the prescribed dose, even though the dose was within clinical guidelines, the patient had been prescribed this dose for over 60 days, and the patient had maintained sobriety with this dose.
b. A UR Agent denied a request for Suboxone for a patient with opioid use disorder, notwithstanding that the UR Agent physician reviewer who should have been conducting an independent clinical review of the quantity limit over-ride request merely "upheld" the decision of a lower level staff person without the clinical expertise to make the decision.

c. A patient was hospitalized for a lengthy period of time, during which time the patient had been prescribed a specific antidepressant, and should have been allowed to continue treatment with this medication. The UR Agent denied the request for continued use of the antidepressant, because the UR Agent did not see clear enough evidence that the patient had tried one of the UR Agent's preferred alternative medications.

d. A patient was denied approval for a prescription drug because of the UR Agent's determination that the patient had not "tried and failed" the UR Agent's preferred alternative medications. The request was denied even though the prescriber justified not engaging in additional trials because the patient's other medical conditions would not permit such trials.

e. A patient hospitalized and approaching discharge following near a lethal overdose and suicide attempt was denied the opportunity to continue therapy with the prescription drug that had permitted the patient to improve sufficiently to be ready for discharge.

f. Seventeen (17) Case Records reviewed by the Examiners demonstrate that the UR Agent unreasonably delayed making a prior authorization decision.

g. Twenty-five (25) Case Records reviewed by the Examiners demonstrate that improper decisions or processes impeded patient care.

Prescription drug recommendations.

35. Blue Cross should implement the following recommendations in order to remediate the noncompliant patterns or practices found by the Examiners and described in Paras. 28-35. On or before September 28, 2018 Blue Cross should propose a Plan of Correction to implement each of the following behavioral health recommendations set forth in Paras. 36-38.

36. Blue Cross should establish the following revised prescription drug utilization review criteria for prescription drugs typically prescribed for behavioral health conditions.

a. The "trial" period for step therapy criteria should be based on consensus, evidence-based, and should permit the prescriber to determine, based on the prescriber's clinical observations, whether an exception to the trial period should be granted if the patient is not responding appropriately to the alternative medication, or if the patient has adverse consequences to the alternative

medication. Blue Cross should propose in its Plan of Correction trial periods consistent with the above principles, subject to the approval of the Commissioner.

b. Step therapy or "fail first" criteria should not be applied unless it is clear that the request is for a new start to the medication. If a patient is being treated with a medication which would otherwise be subject to utilization review, the utilization review request should be approved, including situations where:
    i. The patient has been prescribed the requested medication during a period of hospitalization.
    ii. The request is being renewed.
    iii. Blue Cross should propose in its Plan of Correction policies and procedures satisfactory to the Commissioner in its Plan of Correction how to satisfy 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 issued by Blue Cross, (2) the patient has been prescribed the medication as a member of a health plan issued by a different carrier, and (3) the patient has been prescribed medication from pharmaceutical company samples.
c. The criteria should include an "exceptions policy" that offers prescribers an opportunity to request approval of a prescription drug inconsistent with the utilization review criteria, based on the unique or unusual nature of the patient's clinical condition or circumstances. Such decisions should be considered medical necessity decisions. The physician reviewer should consider, address, and document all information submitted by the ordering provider in connection with the exceptions request.
d. If an FDA guideline is to be used for utilization review of prescription drugs, the guideline should be explicitly incorporated into the utilization review criteria for the specific prescription drug.
e. Step therapy criteria should not require or suggest a trial of an opioid medication.

37. Blue Cross should establish the following revised policies and procedures for utilization review of prescription drugs typically prescribed for behavioral health conditions. Each revised

policy and procedure should be subject to an explicit component of a utilization review program training manual. Compliance with the policies should be monitored by an oversight policy, conducted by Blue Cross. Blue Cross' oversight policy should include direct oversight of utilization review functions sub-delegated from its UR Agent to a third party (for example, Medical Review Institute of America, L.L.C.):

a. If the facts and circumstances presented to the UR Agent suggest reason to believe that clinical information critical to the utilization review decision is missing, the UR Agent should actively solicit the information from the provider, and allow a reasonable period of time for the provider to respond.
b. When prior approval for medication is being requested for a patient who is being discharged from a hospital, the UR Agent should solicit information concerning medications prescribed to the patient during the hospitalization.
c. The initial denial should be made independently, by a provider of the same licensure status as the requesting provider. Blue Cross should propose in its Plan of Correction standards and procedures for how it will ensure that: (1) the UR Agent reviewing provider does not rubber-stamp", or give undue weight to the recommendations, suggestions, notes or comments related to disposition of the service request of lower level or previous decision-making staff or reviewers, and (2) the UR Agent reviewing provider explains his or her decision with sufficient detail to understand why the decision was made, and, if applicable, specifically how the prescriber's facts and rationale were considered.
d. There should be a single process for requesting approval of a medication (including step therapy and fail first requirements), together with requesting approval of the dose or supply of the medication.
e. Utilization review request forms and protocols (in FAX, digital or telephonic forms) used for the utilization review of prescription drugs should conform to the following requirements:
    i. The request forms and protocols must incorporate all of the specific criteria for each prescription drug, and must solicit the specific information needed to meet the criteria for that prescription drug.

ii. The request forms and protocols should reflect a single process for all types of utilization review, including prior authorization, step therapy, or quantity limits.

iii. The request forms and protocols should expressly ask the prescriber whether the request is urgent.

iv. The request forms and protocols should ensure that once the prescriber has demonstrated that the request is for continuation therapy, no additional utilization review questions will be asked or required to be answered, unless in accordance with standards and procedures proposed in Blue Cross' Plan of Correction and approved by the Commissioner.

v. Blue Cross should develop a process to identify out of date fax forms, consolidate forms where possible, and effectively communicate with providers which fax forms should be used to request prior authorization.

f. The utilization review process should require explicit, intentional and documented consideration of whether a potential denial might impede care, delay care, or lead to an inappropriate transition of care or lack of continuity of care.

g. If the UR Agent believes there is insufficient information to make a decision, the prescriber must be notified of what specific information is needed.

h. The UR Agent should consider the patient's claims history information when reviewing utilization review requests.

38. Blue Cross should establish a revised documentation policy for utilization review records for prescription drugs that includes the following requirements. Compliance with the Case Record documentation policy should be subject to an explicit component of a utilization review program training manual. Compliance with the policy should be monitored by an oversight policy, conducted by Blue Cross. The documentation policy should apply to utilization review functions sub-delegated from Blue Cross' UR Agent to a third party (for example, Medical Review Institute of America, L.L.C.):

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

b. Case Records should document in detail all conversations or other communications with the prescriber, and the prescriber's designee.

c. Case Records should document in detail all clinical information offered by the prescriber, and the complete, unabridged rationale for the prescriber's request.
d. Case Records should include the actual review of the UR Agent's physician reviewer, rather than a note made by some other UR Agent non-physician staff concerning the physician's review.
e. The Case Record should include in the UR Agent's physician review documentation that all clinical information was reviewed, and documentation of the reviewer's rationale for rejecting or discounting the requesting prescriber's clinical judgment or recommendation.
f. If a request is pended for insufficient information, the Case Record should document (1) what specific information is needed, (2) communications with the provider, and (3) the provider's response to the communication.
g. Case Records should be collected, organized, and maintained 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.

Wherefore, it is hereby ORDERED:

A. The Commissioner hereby adopts the Examination Report and Recommendations.
B. On or before September 28, 2018, Blue Cross shall file with the Commissioner such policies and procedures it intends to use to eliminate utilization review for in-network behavioral health services, and to adopt a Notice of Admission and Discharge Program (NOA/D Program) and a Case Management Program (collectively "Programs"). Blue Cross' shall discontinue its utilization review program for in-network behavioral health services upon the effective date of the Programs. The Programs shall:
    1. Not adversely impact access to patient care, or patient continuity and transition of care.
    2. Not unreasonably impact provider treatment.
    3. Include reasonable standards and procedures for providers to administratively appeal an adverse decision.

C. Blue Cross shall report to the Commissioner on January 1, 2019 and July 1, 2019 regarding the implementation of the Programs. Such reports shall include: (i) the number of admissions and discharges under the NOA/D Program, (ii) the number of administrative appeals resulting from the NOA/D Program and the disposition of such appeals, (iii) the number of members in Case Management, (iv) and the number of out of network behavioral health services that were subject to each level of utilization review and the disposition of such reviews. Blue Cross shall provide such other information as the Commissioner may reasonably request related to the Programs.

D. Blue Cross shall file with the Commissioner by September 28, 2018 a Plan of Correction, approved by the Commissioner, to implement the Recommendations set forth in Paras. 20-24 (behavioral health services), and 36-39 (prescription drugs). Blue Cross shall implement the approved Plan of Correction, within the time frames set forth in the Plan of Correction.

E. In lieu of a penalty, Blue Cross shall make a behavioral health system infrastructure payment of $5 million, payable in the amount of $1 million each year over 5 years beginning January 1, 2019. 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 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 Blue Cross' costs of implementing this Report's Recommendations and Orders.

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

G. 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. Blue Cross shall pay the costs of any such further actions or supplemental orders.

Dated at Cranston, Rhode Island this 15th day of August, 2018.

Marie Ganim

Marie Ganim, Commissioner

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

Consent of Blue Cross and Blue Shield of Rhode Island

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

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

III. Blue Cross 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: Monica Campanha Date: August 8, 2018

Title: VP, Legal Services