OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Health Insurance Bulletin 2020-08

Issued November 24, 2020

Effective December 1, 2020

Reinstatement of Temporary Emergency Measures Regarding Benefit Determination Review and Network Plans and Health Care Accessibility and Quality Assurance

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The Office of the Health Insurance Commissioner ("OHIC") issues this Bulletin to reinstate, with limited exceptions, the provisions of Health Insurance bulletin 2020-03 "Temporary Emergency Measures Regarding Benefit Determination Review and Network Plans and Health Care Accessibility and Quality Assurance" issued April 27, 2020 [1], to ensure access to and continuity of care as well as the safety and welfare of beneficiaries during the COVID-19 public health crisis.

On March 9, 2020, Governor Raimondo declared a state of emergency ("State of Emergency") due to the dangers to health and life posed by the outbreak of COVID-19 and that declaration has been continually extended since its original date of declaration.[2] On April 27, 2020, Governor Raimondo issued the "Twenty-Sixth Supplemental Emergency Declaration – Promoting Better Coordination of Health Care Coverage" ("Executive Order"), effective April 27, 2020.[3] The Executive Order directs OHIC to issue guidance on its implementation and has been continually extended since its original date of issuance.

As set forth by Governor Raimondo in Executive Order 20-98, issued on November 19, 2020: "despite progress in some key areas, the State continues to suffer from the effects of the

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[1] Health Insurance Bulletin 2020-03 set forth expiration dates for certain provisions contained therein. This Health Insurance Bulletin reinstates, with limited exceptions, those provisions that have expired. The remaining provisions of Health Insurance Bulletin 2020-03 that were not associated with specific expiration dates continue to be in effect and are maintained in this Health Insurance Bulletin. This Health Insurance Bulletin also effectively extends the provisions of Health Insurance Bulletin 2020-04: "Emergency Measures Regarding Benefit Determination Review" issued July 1, 2020 and Health Insurance Bulletin 2020-06 titled "Extension of Bulletin 2020-04: Temporary Emergency Measures Regarding Benefit Determination Review," issued October 1, 2020.

[2] Executive Order 20-02 declaring the State of Emergency due to the dangers to health and life posed by COVID-19 is currently in effect until at least December 3, 2020, pursuant to Executive Order 20-91 issued on November 2, 2020 and titled "EIGHTY-SIXTH SUPPLEMENTAL EMERGENCY DECLARATION - EXTENSION OF VARIOUS EXECUTIVE ORDERS"

[3] Executive Order 20-29, "Promoting Better Coordination of Health Care Coverage" was extended until December 23, 2020 by Executive Order 20-99 issued on November 24, 2020 and titled NINETY-FOURTH SUPPLEMENTAL EMERGENCY DECLARATION - EXTENSION OF VARIOUS EXECUTIVE ORDERS.

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pandemic"; "Rhode Islanders face a new set of challenges going into the winter months, including increased community spread and rising hospitalizations"; "despite the best efforts of public health officials, the incidence of COVID-19 is surging in the country, regionally and in Rhode Island"; and "further aggressive efforts are necessary to slow the spread of COVID-19 and to lessen the strain on our healthcare system". This Bulletin therefore reinstates, with limited exceptions, the instructions of Health Insurance Bulletin 2020-03 to health care entities and benefit determination review agents subject to OHIC's jurisdiction on how to implement the April 27, 2020 Executive Order and maintain compliance with Chapters 27-18.8 and 27-18.9 of the Rhode Island General Laws and regulations promulgated thereunder to ensure access to and continuity of care and the safety and welfare of beneficiaries. Specifically, this bulletin provides temporary regulatory relief to entities under OHIC's jurisdiction as well as instruction to those entities regarding necessary temporary policies and procedures to adopt and follow to maintain adequate and responsive networks, remove unreasonable administrative barriers to providers' capacity to provide and be reasonably reimbursed for necessary covered services, and ensure beneficiaries have timely access to covered services during the State of Emergency. These temporary policies and procedures to be adopted and followed during the State of Emergency center around systemic changes, complaint processes, formularies, network adequacy policies and procedures, credentialing and recredentialing policies and procedures and provider contracting, notification requirements, referral requirements, and benefit determination review policies and practices.

Benefit Determination Review

1. The temporary Benefit Determination Review – Waiver Guide issued by OHIC on March 20, 2020, relating to benefit determination review, as set forth below, are hereby incorporated into this Bulletin, specifically:

    - Benefit Determination Review Agents may provide notifications of non-administrative adverse determinations and appeal decisions electronically in situations where claimants have access to electronic communications in a manner reasonably designed to come to the attention of the member, or verbally with documentation of such communication, provided that: (a) for non-urgent or non-emergent denials, where notification is verbal only, written notification should follow at a reasonable time to be determined by the review agent and until such time as written notification is sent, the claimant's time to appeal the denial shall be tolled; (b) electronic or verbal notifications must include a description of the claimant's appeal rights; and (c) review agents shall maintain all appropriate documentation to support the benefit determination decisions.

    - Waiver of timeframes to notify the claimant of a failure to follow the health care entity's claims procedures and of the specific procedure the claimant has not complied with. However, the review agent may notify the claimant verbally, to ensure access to needed services and continuity of care.

    - Waiver of the timeframes for notification of insufficient information to make a utilization review determination with the exception of verbal and electronic

notifications related to urgent requests.

- All adverse benefit determination decisions and notifications shall be made within a reasonable period of time, considering circumstances, and shall not delay urgent or emergent care. Decision and notification timeframes for urgent and emergent requests are not waived. Note the exception noted above to use verbal and electronic notification processes shall be allowed during this state of emergency.

- The timeframe to request an appeal of non-urgent and non-emergent services shall be 180 days from the written notice, and not from the point when and if electronic or verbal notice is given.

2. **Systemic changes**. A benefit determination review agency ("BDR Agency") will not be required to submit notice of systemic changes at least thirty (30) calendar days in advance of such change if the change is being made in direct response to the COVID-19 pandemic and is being made for the purpose of contributing to efforts to control, contain and/or address the COVID-19 pandemic. The BDR Agency must inform OHIC as soon as possible of such change and in advance of implementation and provide a summary description of such change. Any systemic change so implemented remains subject to OHIC's jurisdiction to limit the effective period of the systemic change or require the rescinding of the systemic change.

   Through the earlier of February 28, 2021 (or an extension of the February 28, 2021 date issued by OHIC as necessary) or the expiration of the Executive Order, BDR Agencies shall refrain from notifying, seeking approval from OHIC for, and/or implementing any systemic change, as that term is defined in 230-RICR-20-30-14.3.A.37, not falling under the above COVID-19 pandemic related exception.

3. **Complaint processes**. A BDR Agency, or where applicable a health care entity, may submit any necessary summary of changes to its complaint processes to OHIC pursuant to which the BDR Agency, or health care entity, will not be held to the regulatory requirement of a 30-day resolution of each complaint, provided the BDR Agency, or the health care entity, establishes a reasonable process and timeframe for resolution of consumer and provider complaints with a focus on prioritizing resolution of telemedicine and COVID-19 related issues that have the potential to more immediately impact the delivery of all urgent and emergent needed care.

4. [Intentionally left blank]

5. **Benefit determination review requirements**. Through the earlier of February 28, 2021 (or an extension or shortening of the February 28, 2021 date issued by OHIC as necessary) or the expiration of the Executive Order, all health care entities and their certified BDR Agencies shall:

   a. Suspend prior authorization requirements for the following in-network services: in-patient facilities, long term care facilities, in-patient rehabilitation, skilled nursing facility, and telemedicine;

b. Suspend all non-administrative benefit determination reviews, including prior authorization, for all in-network behavioral health services;
c. Suspend prior authorization requirements for all in-network non-pharmacy COVID-19 related diagnostic and treatment services;
d. Suspend prior authorization requirements for in-patient COVID-19 related treatment in out-of-network facilities;
e. Not replace suspended prior authorization requirements with new retrospective review requirements;
f. [Intentionally left bank]
g. Revise pharmacy benefit management practices to expedite the approval of needed medications and to reduce the administrative burden on prescribers; and
h. Ensure that any patient or provider that received authorization prior to February 28, 2021 for a service that was delayed due to the pandemic shall be given a reasonable time extension of that approval.

Network Plans and Health Care Accessibility and Quality Assurance

1. **Substantial systemic changes**. A health care entity will not be required to submit notice of substantial systemic changes at least thirty (30) calendar days in advance of such change if the change is being made in direct response to the COVID-19 pandemic and is being made for the purpose of contributing to efforts to control, contain and/or address the COVID-19 pandemic. The health care entity must inform OHIC as soon as possible of such change and in advance of implementation and provide a summary description of such change. Any systemic change so implemented remains subject to OHIC's jurisdiction to limit the effective period of the systemic change or require the rescinding of the systemic change.

   Through the earlier of February 28, 2021 (or an extension of the February 28, 2021 date issued by OHIC as necessary) or the expiration of the Executive Order, health care entities shall refrain from notifying, seeking approval from OHIC for, and/or implementing any substantial systemic change, as that term is defined in 230-RICR-20-30-9.3.A.24, not falling under the above COVID-19 pandemic related exception.

2. **Complaint processes**. A health care entity may submit any necessary summary of changes to its complaint processes to OHIC pursuant to which the health care entity will not be held to the regulatory requirement of a 30-day resolution of each complaint, provided the health care entity establishes a reasonable process and timeframe for resolution of consumer and provider complaints with a focus on prioritizing resolution of telemedicine and COVID-19 related issues that have the potential to more immediately impact the delivery of all urgent and emergent needed care.

3. **Formularies**. Regarding a non-adverse formulary change (i.e., addition of a medication to the formulary, removal of a medication from the formulary when the medication has been determined by a state or federal agency to be harmful to beneficiaries, downward medication tiering changes and/or decreased cost sharing), a health care entity may submit to OHIC for approval, a revised formulary change notification process that the

health care entity will follow in lieu of the regulatory timelines and notification specifications of 230-RICR-20-30-9.6(C)(1-4).

A health care entity shall not remove any medications from its formulary prior to the earlier of February 28, 2021 (or an extension of the February 28, 2021 date issued by OHIC as necessary) or the expiration of the Executive Order unless: a) a health care entity first evaluates and considers any potential significant adverse impact of the removal of a formulary drug, including taking into account the impact of the COVID-19 pandemic on patients and providers and the health care entity's obligation to ensure access to care and continuity of care (and documents this process); or b) the health care entity is informed by a state or federal agency that the medication is harmful to beneficiaries. This requirement does not apply to notices to remove a medication from the formulary that were noticed prior to December 1, 2020. A health care entity also shall not move any medications on its formulary to a higher cost share tier without performing the steps outlined in (a) above. OHIC recognizes that some health care entities may have systemic barriers to strict compliance with some of these formulary provisions. In those situations, a health care entity may seek OHIC approval for a temporary policy and practice that effectively complies with these formulary provisions.

4. **Network Adequacy requirements**. A health care entity may seek expedited approval from OHIC of temporary changes to its current network adequacy policies and procedures to address in network and out of network providers as long as those changes are being implemented in consideration of COVID-19 constraints on providers (inclusive of facility providers) and being made for the purpose of contributing to efforts to control, contain and/or address the COVID-19 pandemic and any anticipated treatment need surges.

5. **Credentialing and re-credentialing requirements**. A health care entity or its delegate may seek expedited approval from OHIC of temporary changes to its current credentialing and re-credentialing policies and procedures to the extent these changes are reasonable and relate to: its need to respond to the COVID-19 pandemic's impact on provider (inclusive of facility provider) limitations; the need to expedite credentialing in response to delivery system needs; and/or the need to comply with any subsequent directive issued by the Health Insurance Commissioner or the Governor in connection with the State of Emergency.

   These temporary changes for which expedited approval may be sought should be understood to include flexibility when establishing transitional and/or provisional credentialing processes defined in 230-RICR-20-30-9.8(C)(1 & 2), such as a more limited credentialing application for the purpose of expediting credentialing and/or provisional/conditional/temporary provider contracting.

   However, a health care entity's contracting requirements for all provider (inclusive of provisional, conditional, and/or temporary provider) contracts must continue to maintain the protections of 230-RICR-20-30-9.9(A)(1)(a-c) in these contracts.

Health care entities shall effectively suspend their re-credentialing requirements of providers, and allow providers to effectively maintain their credentialed status, through the earlier of February 28, 2021 (or an extension of the February 28, 2021 date issued by OHIC as necessary) or the expiration of the Executive Order.

6. **Temporary contracting requirements**. Consistent with the provisions of paragraph 5 above, a health care entity may seek expedited approval from OHIC to include in a provisional and/or conditional and/or temporary provider contract language which reflects that "cause" in the context of a termination "for cause" provision may reasonably include that the health care entity or network plan no longer needs additional providers to address the COVID-19 pandemic.

7. **Removal of Providers/De-credentialing**. Through the earlier of February 28, 2021 (or an extension of the February 28, 2021 date issued by OHIC as necessary) or the expiration of the Executive Order, a health care entity shall not remove any licensed provider from its network unless fraud or patient harm are indicated or the provider is identified by the Office of the Inspector General for the U.S. Department of Health and Human Services as excluded from participation in federal health care benefit programs.

8. **Provider Directories**. Health care entities shall strive to meet the pre-Executive Order requirements of 230-RICR-20-30-9.7.D.4. However, where good cause is shown, OHIC shall not require strict compliance with those requirements provided the health care entity reasonably addresses beneficiary complaints resulting from an inaccurate provider directory or inaccurate network plan information given to a beneficiary telephonically or electronically by the health care entity.

9. **Different site of service/care and or unreported provider demographic changes.** Through the earlier of February 28, 2021 (or an extension of the February 28, 2021 date issued by OHIC as necessary) or the expiration of the Executive Order, a health care entity shall not deny claims for payment based on a different site of service/care that the provider may be practicing from or based on unreported provider demographic changes attributable to the COVID-19 pandemic.

10. **Notification Requirements**. Through the earlier of February 28, 2021 (or an extension of the February 28, 2021 date issued by OHIC as necessary) or the expiration of the Executive Order, all health care entities shall reasonably relax notification requirements to account for the COVID-19 pandemic and its impact on providers (inclusive of facility providers), including provider staffing levels, which relaxation shall include allowing retroactive notification for good cause.

11. **Referral requirements**. Through the earlier of February 28, 2021 (or an extension of the February 28, 2021 date issued by OHIC as necessary) or the expiration of the Executive Order, all health care entities shall:

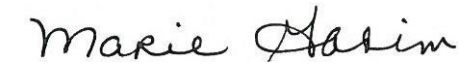
    a. Suspend referral requirements for in-network behavioral health care services;
    b. Suspend any referral requirements for in network services delivered via telemedicine that are more stringent than referral requirements for the same in-network services delivered in-person.

c. Ensure all referrals issued as of the effective date of this Bulletin shall remain in effect for a minimum of 180 days, regardless of the number of visits to the referred specialist during the 180 days;
d. Allow required referrals to be submitted retroactively for at least 21 days following the date of service, without penalty to the provider or beneficiary;
e. Develop policies and/or practices to reasonably provide leniency in extending referral end dates and waiving referral requirements for in-network services; and
f. Temporarily expand and/or create a reasonably robust list of permitted in-network self-referral specialists and/or services.

Health care entities and BDR Agencies shall promptly notify participating providers of the policy changes made in response to this Bulletin.

This Bulletin shall take effect December 1, 2020 and remain in full force and effect for as long as the Executive Order remains in effect, including through renewal, modification or termination by subsequent Executive Order.

Dated at Cranston, Rhode Island this 24th day of November 2020.



Marie Ganim, PhD., Commissioner