State of Rhode Island and Providence Plantations
OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 Pontiac Avenue, Building 69
Cranston, Rhode Island 02920

FINAL CONCISE EXPLANATORY STATEMENT FOR PROPOSED REGULATION 230-RICR-30-20-9 – NETWORK PLANS

A. Introduction. Pursuant to R.I. Gen. Laws § 42-35-2.6, the Rhode Island Department of Business Regulation ("Department") is hereby providing a final Concise Explanatory Statement for proposed regulation 230-RICR-30-20-9 – Network Plans.

B. Statement of Purpose of the Proposed Regulation.

This regulatory action was taken in order to:

1. Enforce the Office of the Office of Health Insurance Commissioner jurisdiction and statute RIGL 27-18.8, the Health Care Accessibility and Quality Assurance Act (the Act) effective on January 1, 2018.
2. Prior to OHIC's jurisdiction, similar protections of the Act and subsequent regulations were under the jurisdiction of the Rhode Island Department of Health (HEALTH). The current Act reflects not only the change to OHIC's jurisdiction but reflects changes to bring the Act to current national protective standards to assure that health care entities maintain network adequacy, quality, continuity and reasonable access to covered benefits.
3. The statute was updated accordingly, and the proposed regulations designed and developed to clarify, for the health care entities, the expectations in order to comply with mandated requirements of the Act.

C. Summary of the Regulatory Analysis. In adopting the Office's proposed regulation for Network Plans, the Office determined that there are minimal overall costs to the health care entities/network plans and providers, and great benefits to the consumers. The Office improved the ease of compliance by eliminating non-essential content and clarifying points of potential confusion for regulated parties, including: defining and clarifying delegate requirements, establishing a two-year cycle for recertification of network plans, creating a mechanism in the compliant and grievance process around communication for consumers, streamlining the referral process, expanding to create an expedited credentialing process and ensuring network adequacy for consumers. Requests for the full regulatory analysis may be emailed to alyssa.metivier@ohic.ri.gov.

D. Summary of Post-Comment Changes: There are several differences between the text of the proposed rules as published in accordance with R.I. Gen. Laws § 42-35-2.7 and the rule as adopted. These changes are all consistent with, and a logical outgrowth of, the amendments

in the notice of proposed rulemaking in accordance with R.I. Gen. Laws § 42-35-6.1. In addition to this summary of changes, a redlined document showing the exact changes is attached.

1. *Definitions - § 9.3(A)(1).* Commentary was received regarding the definition of "active treatment". OHIC has made a change in the definition from "attests" to "substantiates" to clarify that the condition being treated by the attending providers is justified. The definition of active treatment is consistent with the federal ACA and industry standard.

2. *Definitions - § 9.3(A)(16) and 9.3(A)(24)* Commentary was received suggesting the deletion of "and/or", the Office made the appropriate changes for section 9.3(A)(16). Also, commentary was received to provide further clarification on the definition of substantial systemic change in section 9.3(A)(24). The Office included the statement "relevant to these regulations" to provide further clarification based on comments received.

3. *Network Plan General Requirements - § 9.6(C)(1) and 9.6(C)(3).* Commentary was received regarding section 9.6(C). The Office changed the word "changes" to "development" to address the network plan providers' input to formularies. Also, commentary was received to change the notification of a substantial systemic change from 30 calendar days to 90 days. The 30-calendar day notification is direct from statute – RIGL 27-18.8-3(b)(3) and cannot be amended without legislative change and is in accordance with RIGL 27-15-50 which requires health insurance carriers, inclusive of health care entities at least a 30-day notification. The Office has made the change to include "at least" in front of 30 days that references a substantial systemic change to comply with the statute.

4. *Network Adequacy Requirements - § 9.7(A)(3)(b-c).* OHIC has moved 9.7(A)(3)(b) and (c) to provide clarification to the health care entities on the procedures for addressing network adequacy.

5. *Network Adequacy Requirements - § 9.7(D)(2)(c)(3) and 9.7(D)(3-5).* The Office clarifies section 9.7(D)(2)(c)(3). Commentary was received suggesting an amendment to the addition of the provider directory information to ID cards. The Office has removed "clearly evidenced" and included "referenced". The industry standard is to include a web address on the provider ID card, to bring the member to an up-to-date provider directory. It is important for consumers to have access to the most up-to-date provider directory, in order to ensure the member receives services at an in-network provider. The Office is establishing a format that is acceptable to the Commissioner.

6. *Professional Provider Credentialing and Re-Credentialing - § 9.8(A)(4) and (C)(1) and (D).* Commentary was received regarding clarification on the credentialing and

re-credentialing processes. OHIC made the change to include the re-credentialing requirements, if applicable to the health care entity. Also, commentary was received regarding clarification on the above listed sections, suggesting to only include the transitional approval of resident graduates. The Office is looking for an expedited process if there is a "need" for any provider type. OHIC has changed the word "determined" to "assessed" as the Commissioner is evaluating the need presented by the health care entity. It allows flexibility of the health care entity to inform OHIC of its process to address need as cited in (C). The statutory support of this section applies to network adequacy.

7. *Provider Contracting and Due Process - § 9.9(A)(1)(a) and (A)(3)(a-c).* Commentary was received regarding the above listed sections. The Office has added language in section 9.9(A)(1)(a) to further clarify the provisions protecting beneficiaries. The Office removed section (A)(3)(a-c) to address concerns we received in public comment.

E. Summary of Comments Not Resulting in Regulatory Language Changes. Below is a summary of other public comments received (public hearing testimony, in addition to oral and written public comments) that did not result in changes to the text of the Regulation and a brief description of the Office reasons for not making any such changes after due consideration.

1. *Suggested amendment to § 9.3(A)(10) – Definitions.* Commentary was received in opposition of the definition of "covered service". It was proposed that the definition of "covered service" be changed to reimbursed in whole or in part to the dentist (provider) per section 27-18.8-4 of the Act. Section 27-18.8-4 reference to covered service is only applicable to dentists for this specific section and not applicable to the entire Act and subsequent regulations. In the regulation, the Office took the industry standard definition of covered service and believe it is adequate for the proposed regulation. Additional commentary was received to address the letter received in opposition of the "covered service" definition. The commentary agreed with the Office's industry standard definition of a "covered service". A request to add the definition of behavioral health was received in public comment. The Office believes the definition of health care services in both statute and mimicked in regulations include behavioral health. To define this, which has the potential to change with time, would require OHIC to define all types of health care services, which is why OHIC used the definition to include but is not limited to include services not yet developed.

2. *Clarification on § 9.3(A)(16) and 9.3(A)(24) – Definitions.* Commentary was received regarding the definition of substantial systemic change. More specifically the section in the definition "for a significant number of beneficiaries" will this be a percentage of a fixed number in determining what is significant. Also, in the definition, "operational policies and procedures adversely

affecting beneficiaries", if these policies and procedures only affect network access. In the section A(24), the Office is requesting to be noticed of any substantial changes, but not necessarily determining that all are material at that time or that a material change application would be required to be submitted for approval by OHIC.

3. *Suggested amendment to § 9.4(A)(4) – General Requirements - Certification, Recertification, and Material Change.* Commentary was received to add language directly from statute, RIGL 27-18.8-3(a)(2) which states the Commissioner will act upon healthcare entities' completed application for certification of network plans within 90 days of receipt of the application for certification. As this is directly in statute, the Office has determined it does not need to be in regulation. Regulations are created in order to guide the entities in complying with state statutes.

4. *Clarification on §9.5 and 9.5(B)(3) Delegate Requirements.* Commentary was received to clarify what type of delegation is covered in this particular act as well as what direct access to all the information held by the delegate means. OHIC has jurisdiction over all of the entities and its delegates for which relevant sections of this Act apply, including the delegation of benefit review determinations. Not all entities delegate contracts and reconciliation of issues to its delegates and putting in language with all delegate contact information may not be appropriate, expeditious, or in the best interest of the consumer or provider in reconciling issues. In terms of notifying beneficiaries and providers of delegate changes, that is part of the material change process of this Act and subsequent regulations.

5. *Suggested amendment to § 9.6(A)(2) – Network Plan General Requirements*. Commentary was received suggesting an amendment to 30-day maximum turn-around for the resolution of complaints. In drafting these regulations and reviewing this commentary, the Office gave due consideration to the requirement of Network Plans complaint process to provide for enough flexibility to develop internal policies, with the approval from OHIC, to allow for the use of extensions past the required 30-day turnaround. For example, the beneficiary or authorized representative could consent to extending resolution timeline. Such circumstances and processes would then be outlined in the Network Plan policies and procedures and certification application if applicable. The focus of this section is to fully investigate and provide a well-considered timely resolution to the provider and/or member.

6. *Suggested amendment to § 9.6(A)(3) – Network Plan General Requirements.* Commentary was received suggesting an amendment to the required annual communication to members and dentist explaining grievance processes. The

section requires communication at least annually, to beneficiaries and providers, that explains the grievance and complaint process. Information regarding the grievance and complaint process could be sent along with a mass provider/member newsletter, or via annual communications to the member regarding their summary plan descriptions, perhaps even with an explanation of benefits. Including such information regarding the grievance and complaint process is a vital protection to the consumer. The Office leaves the flexibility up to the health care entity how to incorporate this information with other provider and member communications.

7. *Suggested amendment to § 9.6(B)(2) and 9.6(C)(1) – Network Plan General Requirements.* Commentary was received on the above sections surrounding health care policies and formulary requirements input. Through this regulation, the Office requires that the carriers to substantiate an effective process to meet these requirements as part of the application certification review.

8. *Suggested amendment to § 9.6(C)(2), 9.6(C)(3), 9.6(C)(2)(c) – Network Plan General Requirements.* Commentary was received on the above section regarding non-medical switching be added into this regulation. Non-medical switching is outside the purview of OHIC's jurisdiction, however these regulations require carriers to have adequate processes to address formulary change, exceptions processes and notifications to providers and consumers. Also, commentary was received in regard to provider input on section C(2)(c) around cost sharing. The Office understands that providers are not involved in cost sharing decisions but input as to the impact of cost sharing is important to the quality and continuity of care given the level and frequency of formulary changes.

9. *Clarification on § 9.6(E) and 9.6(F) – Network Plan General Requirements.* Commentary was received regarding clarification on the quality assurance program. The Office will require an adequate process within the scope of the health care entity quality control program relative to the requirements of these regulations and the Act which may include a separate committee. This cannot be evaluated or answered without looking at the health care entity's entire application for certification. Also, commentary was received whether a submission of an attestation would be sufficient to meet the requirement in section 9.6(F). The Office has determined that attestations will not solely be used to determine compliance.

10. *Suggested amendment to § 9.7(A), 9.7(A)(1) and 9.7(A)(3)(a) – Network Adequacy Requirements.* For section § 9.7A(1), commentary was received to remove the types of beneficiaries. The network plans are being asked to submit their policies to meet its population needs. The policies will then be assessed for

network adequacy based on the information of scope, of the beneficiary and network base. Commentary was received regarding § 9.7(A)(3)(a) asking for clarification on metrics. Any metrics with supporting documentation to show compliance with this section will be provided by the Network Plan for review by OHIC.

11. *Suggested amendment to § 9.7(A)(3) – Network Adequacy Requirements.* Commentary was received to remove language surrounding holding members harmless in the event that the health care entity fails to maintain sufficient provider contracts. OHIC is asking carriers to have adequate networks to provide the covered benefits for the plans it is offering/selling under its approved RI network plans without delay (that includes due to generally accepted travel times that would be part of its certification application), and when the health care entity doesn't have adequate networks. OHIC is asking for procedures to hold the member harmless with the exception of in-network cost shares. In reviewing a Network Plan's description of the circumstances and policies in which it holds the member harmless due to the lack of availability of a network provider, OHIC considers its responsibilities to balance affordability of plans. There is flexibility within this section of the regulations as to how the Network Plan meets this requirement.

12. *Suggested amendment to § 9.7(C)(1)(d) and 9.7(D)(2)(b-c) – Network Adequacy Requirements.* Commentary was received about the above listed sections surrounding transition of care policies. The suggestions include removing "new beneficiaries in active treatment" as well as removing "telehealth" in section (D)(2)(b). In section 9.7(C)(1), the lead in requirements state to include but is not limited to as this section generally requires health care entities to have a transition of care requirement for all beneficiaries (new and existing) in active treatment as this is a quality and continuity requirement per these regulations. Additionally, telehealth in section D(2)(b) is a mandated benefit in Rhode Island and must be covered to the extent of the statute.

13. *Suggested amendment to § 9.7(D)(4) and 9.7(D)(3)(b) – Network Adequacy Requirements.* Commentary was received suggesting an amendment to electronic and paper directories being updated at least every fifteen days with daily updates available telephonically and the deletion of paper directories. The proposed regulation reads at least monthly and gives the network plans flexibility to have their own internal policies that could be shorter than monthly. Also, commentary was received regarding the provider directory being printed in section 9.7(D)(3)(b). The Office is not asking that the directories be printed but that if paper is requested that the directories must have been updated within the past month. There is flexibility within the regulation and it should be no more burdensome

than keeping electronic versions up to date. More frequent updates outside of telephonic could be burdensome and risk inaccuracies.

14. *General comment on §9.6(C)3, 9.9(A)(1)(a), 9.9(A)(1)(b), and 9.9(A)2 – Network Plan General Requirements and Provider Contracting & Due Process.* Commentary was received in support of the above listed sections which encompass formulary changes, the referral process, facility fees and continuity of care for consumers.

15. *Suggested amendments to § 9.8 (A), 9.8(A)(3)(c), (A)(4), and (D)- Professional Provider Credentialing and Re-Credentialing.* Commentary was received regarding expanding credentialing requirements to include re-credentialing. Through the statute and in this regulation, the Office interpretation is the process in which the carriers are maintaining the credentialing of providers. Therefore, the credentialing process is inclusive of re-credentialing. Commentary was received suggesting amendments to the above sections to apply CAQH credentialing and re-credentialing guidelines. The Office allows for the health care entities to choose their credentialing guidelines as long as they meet the guidelines set forth in this regulation. If the Office were to list a particular organizations criterion and it becomes no longer valid, it could cause unnecessary change to the regulation. Also, comments were received on section 9.4(A)(4), in regard to re-credentialing. The Office is looking for what the process is and that there is flexibility surrounding it.

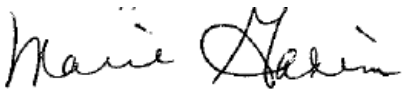
    Regarding section 9.8(D), this section is referring to the actual application, though it does interface with 9.8(A)(2). This section (9.8(D)), defines what a complete application is. Also, additional requirements can be submitted as part of the application, but it must be approved by the Commissioner. There are opportunities and no prohibition of including additional information, with prior submission of this additional information for approval by the Commissioner in (D).

16. *Suggested amendments to § 9.9(A)(1)(a)- Provider Contracting and Due Process.* Commentary was received with a request to remove or modify this section not holding the member harmless when a contracted provider has failed to comply with its contractual obligations to include Network Plan policies and procedures for issuing member referrals. In the event the member has met the obligations of the beneficiary agreement in seeking a referral, OHIC believes this section is necessary to protect the consumer This section does not apply to instances where the member self-refers.

17. *Suggested amendment to § 9.9(B)(3) and 9.9(G) – Provider Contracting and Due Process.* Commentary was received on the above sections to modify the language in each, by changing the timeframe as well as removing an entire section. Both section 9.9(B)(3) and 9.9(G) are statutory [RIGL 27-18.8-3(d)(10) and RIGL 27-18.8-3(d)(6)] and cannot be changed.

18. *Clarification on § 9.10 – Reporting.* Commentary was received regarding clarification of this section as to the date of when the report is due. As stated in the regulation, the network plan complaint report is due annually on or before March 1st of each calendar year. The Office has sent out instructions to the applicable network plans listing the categories required for the first complaint report that falls within the timeline stated in these regulations.

Commissioner's Approval



Marie L. Ganim, PhD
Commissioner

10/25/2018
Date