COVID-19 Communication for Contracted Providers in Rhode Island.

In accordance with the Rhode Island OHIC Bulletin 2021-03 effective May 26, 2021, Aetna has modified its process to support the following requirements:

Benefit Determination Review Agents (Aetna Life Insurance Company and CVS Health Pharmacy):

- Notifications of non-administrative adverse determinations and appeal decisions may be provided 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 will 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 will include a description of the claimant's appeal rights; and (c) review agents will maintain all appropriate documentation to support the benefit determination decisions.
- Waiver of timeframes to notify a 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 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 will 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.

Through June 10, 2021:

a. Suspended 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. Suspended all non-administrative benefit determination reviews, including prior authorization for all in-network behavioral health services;
c. Suspended prior authorization requirements for all in-network non-pharmacy COVID-19 related diagnostic and treatment services
d. Suspended prior authorization requirements for in-patient COVID-19related treatment in out-of-network facilities;
e. Not replace suspended prior authorization requirements with new retrospective review requirements.
f. [intentionally left blank]
g. Will 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 May 31, 2021 for a service that was delayed due to the pandemic shall begiven a reasonable time extension of that approval.

Formularies: Regarding non-adverse formulary changes (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):

- Medications will not be removed from its formulary prior to the earlier of June 10, 2021 (unless a) consideration isfirst given to any potential significant adverse impact of the removal of a formulary drug taking into account the impact of the COVID-19 pandemic onpatients and providers to ensure access to care and continuity of care; or b) 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. Medications on its formulary will not be moved to a higher cost share tier without performing the steps outlined in (a) above.

Different site of service/care and or unreported provider demographic changes: Through June 10, 2021, claims will not be denied 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.

Notification Requirements: Through June 10, 2021, various notification requirements are relaxed 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 notificationfor good cause.

Referral requirement: Through June 10, 2021:

a. Suspended referral requirements for in-network behavioral health care services;
b. Suspended 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. 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. Reasonably provide leniency in extending referral end dates and waiving referral requirements for in-network services; and
f. As needed, temporarily expand and/or create a reasonably robust list of permitted in-network self-referral specialists and/or services.