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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2025

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A N A C T

RELATING TO INSURANCE -- BENEFIT DETERMINATION AND UTILIZATION
REVIEW ACT

Introduced By: Representatives McGaw, Kislak, Tanzi, Speakman, Boylan, Diaz,
Stewart, Donovan, Morales, and Edwards

Date Introduced: January 22, 2025

Referred To: House Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 27-18.9-5 of the General Laws in Chapter 27-18.9 entitled "Benefit
2 Determination and Utilization Review Act" is hereby amended to read as follows:

3 **27-18.9-5. Administrative and non-administrative benefit determination procedural**
4 **requirements.**

5 (a) Procedural failure by claimant.

6 (1) In the event of the failure of claimant or an authorized representative to follow the
7 healthcare entities claims procedures for a pre-service claim the healthcare entity or its review agent
8 must:

9 (i) Notify claimant or the authorized representative, as appropriate, of this failure as soon
10 as possible and no later than five (5) calendar days following the failure and this notification must
11 also inform claimant of the proper procedures to file a pre-service claim; and

12 (ii) Notwithstanding the above, if the pre-service claim relates to urgent or emergent
13 healthcare services, the healthcare entity or its review agent must notify and inform claimant or the
14 authorized representative, as appropriate, of the failure and proper procedures within twenty-four
15 (24) hours following the failure. Notification may be oral, unless written notification is requested
16 by the claimant or authorized representative.

17 (2) Claimant must have stated name, specific medical condition or symptom and specific
18 treatment, service, or product for which approval is requested and submitted to proper claim

1 processing unit.

2 (b) Utilization review agent procedural requirements:

3 (1) All initial, prospective, and concurrent non-administrative, adverse benefit
4 determinations of a healthcare service that had been ordered by a physician, dentist, or other
5 practitioner shall be made, documented, and signed by a licensed practitioner with the same
6 licensure status as the ordering provider;

7 (2) Utilization review agents are not prohibited from allowing appropriately qualified
8 review agency staff from engaging in discussions with the attending provider, the attending
9 provider's designee or appropriate healthcare facility and office personnel regarding alternative
10 service and/or treatment options. Such a discussion shall not constitute an adverse benefit
11 determination; provided, however, that any change to the attending provider's original order and/or
12 any decision for an alternative level of care must be made and/or appropriately consented to by the
13 attending provider or the provider's designee responsible for treating the beneficiary and must be
14 documented by the review agent; and

15 (3) A utilization review agent shall not retrospectively deny authorization for healthcare
16 services provided to a covered person when an authorization has been obtained for that service
17 from the review agent unless the approval was based upon inaccurate information material to the
18 review or the healthcare services were not provided consistent with the provider's submitted plan
19 of care and/or any restrictions included in the prior approval granted by the review agent.

20 (c) Step therapy exceptions.

21 (1) For purposes of this section, the following terms shall have the following meanings:

22 (i) "Healthcare professional" means a physician or other healthcare practitioner licensed,
23 accredited, or certified to perform specified healthcare services consistent with state law.

24 (ii) "Insurer" has the meaning set forth in § 27-20.7-2.

25 (iii) "Step therapy" means a protocol or program that establishes a specific sequence in
26 which prescription drugs, therapies, medical tests, or other services for a specified medical
27 condition are covered by an insurer.

28 (2) Implementation.

29 (i) When an insurer uses a step therapy protocol to deny or restrict coverage of a
30 prescription drug, therapy, medical test, or other service prescribed by a healthcare professional to
31 diagnose or treat any medical condition, the insurer shall grant an exception to permit immediate
32 coverage if the step it requires:

33 (A) Is contraindicated or expected to cause an adverse reaction;

34 (B) Has been tried and found to be ineffective;

- 1 (C) Has not been tried, but is expected to be ineffective;
2 (D) Will delay or prevent medically necessary care; or
3 (E) Will disrupt the patient's current effective drug regimen.
4 (ii) Insurers shall create a clear, easily accessible, and convenient process for healthcare
5 professionals to submit exception requests online.
6 (iii) Insurers shall approve or deny the exception request within seventy-two (72) hours
7 from receipt of the request. If the healthcare professional identifies the request as an urgent
8 medically necessary service, the insurer shall approve or deny the request within twenty-four (24)
9 hours of receipt of the request. If no determination occurs within these time frames, the request
10 shall be presumed granted.
11 (3) Insurers shall ensure that individuals who review or discuss exceptions with healthcare
12 professionals are themselves healthcare professionals with expertise in the medical service for
13 which an exception is sought.
14 (4) The determinations shall be valid for the length of time deemed medically necessary by
15 the provider, up to one year from the date of the determination.
16 (5) Insurers shall provide the office of health insurance commissioner information and
17 documents about their use of step therapy protocols that permit an accurate analysis of whether step
18 therapy protocols have been used to delay or deny medically necessary care.

19 SECTION 2. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The
20 Rhode Island Health Care Reform Act of 2004 — Health Insurance Oversight" is hereby amended
21 to read as follows:

22 **42-14.5-3. Powers and duties.**

23 The health insurance commissioner shall have the following powers and duties:

24 (a) To conduct quarterly public meetings throughout the state, separate and distinct from
25 rate hearings pursuant to § 42-62-13, regarding the rates, services, and operations of insurers
26 licensed to provide health insurance in the state; the effects of such rates, services, and operations
27 on consumers, medical care providers, patients, and the market environment in which the insurers
28 operate; and efforts to bring new health insurers into the Rhode Island market. Notice of not less
29 than ten (10) days of the hearing(s) shall go to the general assembly, the governor, the Rhode Island
30 Medical Society, the Hospital Association of Rhode Island, the director of health, the attorney
31 general, and the chambers of commerce. Public notice shall be posted on the department's website
32 and given in the newspaper of general circulation, and to any entity in writing requesting notice.

33 (b) To make recommendations to the governor and the house of representatives and senate
34 finance committees regarding healthcare insurance and the regulations, rates, services,

1 administrative expenses, reserve requirements, and operations of insurers providing health
2 insurance in the state, and to prepare or comment on, upon the request of the governor or
3 chairpersons of the house or senate finance committees, draft legislation to improve the regulation
4 of health insurance. In making the recommendations, the commissioner shall recognize that it is
5 the intent of the legislature that the maximum disclosure be provided regarding the reasonableness
6 of individual administrative expenditures as well as total administrative costs. The commissioner
7 shall make recommendations on the levels of reserves, including consideration of: targeted reserve
8 levels; trends in the increase or decrease of reserve levels; and insurer plans for distributing excess
9 reserves.

10 (c) To establish a consumer/business/labor/medical advisory council to obtain information
11 and present concerns of consumers, business, and medical providers affected by health insurance
12 decisions. The council shall develop proposals to allow the market for small business health
13 insurance to be affordable and fairer. The council shall be involved in the planning and conduct of
14 the quarterly public meetings in accordance with subsection (a). The advisory council shall develop
15 measures to inform small businesses of an insurance complaint process to ensure that small
16 businesses that experience rate increases in a given year may request and receive a formal review
17 by the department. The advisory council shall assess views of the health provider community
18 relative to insurance rates of reimbursement, billing, and reimbursement procedures, and the
19 insurers' role in promoting efficient and high-quality health care. The advisory council shall issue
20 an annual report of findings and recommendations to the governor and the general assembly and
21 present its findings at hearings before the house and senate finance committees. The advisory
22 council is to be diverse in interests and shall include representatives of community consumer
23 organizations; small businesses, other than those involved in the sale of insurance products; and
24 hospital, medical, and other health provider organizations. Such representatives shall be nominated
25 by their respective organizations. The advisory council shall be co-chaired by the health insurance
26 commissioner and a community consumer organization or small business member to be elected by
27 the full advisory council.

28 (d) To establish and provide guidance and assistance to a subcommittee ("the professional-
29 provider-health-plan work group") of the advisory council created pursuant to subsection (c),
30 composed of healthcare providers and Rhode Island licensed health plans. This subcommittee shall
31 include in its annual report and presentation before the house and senate finance committees the
32 following information:

33 (1) A method whereby health plans shall disclose to contracted providers the fee schedules
34 used to provide payment to those providers for services rendered to covered patients;

1 (2) A standardized provider application and credentials verification process, for the
2 purpose of verifying professional qualifications of participating healthcare providers;

3 (3) The uniform health plan claim form utilized by participating providers;

4 (4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit
5 hospital or medical service corporations, as defined by chapters 19 and 20 of title 27, to make
6 facility-specific data and other medical service-specific data available in reasonably consistent
7 formats to patients regarding quality and costs. This information would help consumers make
8 informed choices regarding the facilities and clinicians or physician practices at which to seek care.
9 Among the items considered would be the unique health services and other public goods provided
10 by facilities and clinicians or physician practices in establishing the most appropriate cost
11 comparisons;

12 (5) All activities related to contractual disclosure to participating providers of the
13 mechanisms for resolving health plan/provider disputes;

14 (6) The uniform process being utilized for confirming, in real time, patient insurance
15 enrollment status, benefits coverage, including copays and deductibles;

16 (7) Information related to temporary credentialing of providers seeking to participate in the
17 plan's network and the impact of the activity on health plan accreditation;

18 (8) The feasibility of regular contract renegotiations between plans and the providers in
19 their networks; and

20 (9) Efforts conducted related to reviewing impact of silent PPOs on physician practices.

21 (e) To enforce the provisions of title 27 and title 42 as set forth in § 42-14-5(d).

22 (f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The
23 fund shall be used to effectuate the provisions of §§ 27-18.5-9 and 27-50-17.

24 (g) To analyze the impact of changing the rating guidelines and/or merging the individual
25 health insurance market, as defined in chapter 18.5 of title 27, and the small-employer health
26 insurance market, as defined in chapter 50 of title 27, in accordance with the following:

27 (1) The analysis shall forecast the likely rate increases required to effect the changes
28 recommended pursuant to the preceding subsection (g) in the direct-pay market and small-employer
29 health insurance market over the next five (5) years, based on the current rating structure and
30 current products.

31 (2) The analysis shall include examining the impact of merging the individual and small-
32 employer markets on premiums charged to individuals and small-employer groups.

33 (3) The analysis shall include examining the impact on rates in each of the individual and
34 small-employer health insurance markets and the number of insureds in the context of possible

1 changes to the rating guidelines used for small-employer groups, including: community rating
2 principles; expanding small-employer rate bonds beyond the current range; increasing the employer
3 group size in the small-group market; and/or adding rating factors for broker and/or tobacco use.

4 (4) The analysis shall include examining the adequacy of current statutory and regulatory
5 oversight of the rating process and factors employed by the participants in the proposed, new
6 merged market.

7 (5) The analysis shall include assessment of possible reinsurance mechanisms and/or
8 federal high-risk pool structures and funding to support the health insurance market in Rhode Island
9 by reducing the risk of adverse selection and the incremental insurance premiums charged for this
10 risk, and/or by making health insurance affordable for a selected at-risk population.

11 (6) The health insurance commissioner shall work with an insurance market merger task
12 force to assist with the analysis. The task force shall be chaired by the health insurance
13 commissioner and shall include, but not be limited to, representatives of the general assembly, the
14 business community, small-employer carriers as defined in § 27-50-3, carriers offering coverage in
15 the individual market in Rhode Island, health insurance brokers, and members of the general public.

16 (7) For the purposes of conducting this analysis, the commissioner may contract with an
17 outside organization with expertise in fiscal analysis of the private insurance market. In conducting
18 its study, the organization shall, to the extent possible, obtain and use actual health plan data. Said
19 data shall be subject to state and federal laws and regulations governing confidentiality of health
20 care and proprietary information.

21 (8) The task force shall meet as necessary and include its findings in the annual report, and
22 the commissioner shall include the information in the annual presentation before the house and
23 senate finance committees.

24 (h) To establish and convene a workgroup representing healthcare providers and health
25 insurers for the purpose of coordinating the development of processes, guidelines, and standards to
26 streamline healthcare administration that are to be adopted by payors and providers of healthcare
27 services operating in the state. This workgroup shall include representatives with expertise who
28 would contribute to the streamlining of healthcare administration and who are selected from
29 hospitals, physician practices, community behavioral health organizations, each health insurer, and
30 other affected entities. The workgroup shall also include at least one designee each from the Rhode
31 Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the
32 Rhode Island Health Center Association, and the Hospital Association of Rhode Island. In any year
33 that the workgroup meets and submits recommendations to the office of the health insurance
34 commissioner, the office of the health insurance commissioner shall submit such recommendations

1 to the health and human services committees of the Rhode Island house of representatives and the
2 Rhode Island senate prior to the implementation of any such recommendations and subsequently
3 shall submit a report to the general assembly by June 30, 2024. The report shall include the
4 recommendations the commissioner may implement, with supporting rationale. The workgroup
5 shall consider and make recommendations for:

6 (1) Establishing a consistent standard for electronic eligibility and coverage verification.

7 Such standard shall:

8 (i) Include standards for eligibility inquiry and response and, wherever possible, be
9 consistent with the standards adopted by nationally recognized organizations, such as the Centers
10 for Medicare & Medicaid Services;

11 (ii) Enable providers and payors to exchange eligibility requests and responses on a system-
12 to-system basis or using a payor-supported web browser;

13 (iii) Provide reasonably detailed information on a consumer's eligibility for healthcare
14 coverage; scope of benefits; limitations and exclusions provided under that coverage; cost-sharing
15 requirements for specific services at the specific time of the inquiry; current deductible amounts;
16 accumulated or limited benefits; out-of-pocket maximums; any maximum policy amounts; and
17 other information required for the provider to collect the patient's portion of the bill;

18 (iv) Reflect the necessary limitations imposed on payors by the originator of the eligibility
19 and benefits information;

20 (v) Recommend a standard or common process to protect all providers from the costs of
21 services to patients who are ineligible for insurance coverage in circumstances where a payor
22 provides eligibility verification based on best information available to the payor at the date of the
23 request of eligibility.

24 (2) Developing implementation guidelines and promoting adoption of the guidelines for:

25 (i) The use of the National Correct Coding Initiative code-edit policy by payors and
26 providers in the state;

27 (ii) Publishing any variations from codes and mutually exclusive codes by payors in a
28 manner that makes for simple retrieval and implementation by providers;

29 (iii) Use of Health Insurance Portability and Accountability Act standard group codes,
30 reason codes, and remark codes by payors in electronic remittances sent to providers;

31 (iv) Uniformity in the processing of claims by payors; and the processing of corrections to
32 claims by providers and payors;

33 (v) A standard payor-denial review process for providers when they request a
34 reconsideration of a denial of a claim that results from differences in clinical edits where no single,

1 common-standards body or process exists and multiple conflicting sources are in use by payors and
2 providers.

3 (vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual
4 payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of
5 detecting and deterring fraudulent billing activities. The guidelines shall require that each payor
6 disclose to the provider its adjudication decision on a claim that was denied or adjusted based on
7 the application of such edits and that the provider have access to the payor's review and appeal
8 process to challenge the payor's adjudication decision.

9 (vii) Nothing in this subsection shall be construed to modify the rights or obligations of
10 payors or providers with respect to procedures relating to the investigation, reporting, appeal, or
11 prosecution under applicable law of potentially fraudulent billing activities.

12 (3) Developing and promoting widespread adoption by payors and providers of guidelines
13 to:

14 (i) Ensure payors do not automatically deny claims for services when extenuating
15 circumstances make it impossible for the provider to obtain a preauthorization before services are
16 performed or notify a payor within an appropriate standardized timeline of a patient's admission;

17 (ii) Require payors to use common and consistent processes and time frames when
18 responding to provider requests for medical management approvals. Whenever possible, such time
19 frames shall be consistent with those established by leading national organizations and be based
20 upon the acuity of the patient's need for care or treatment. For the purposes of this section, medical
21 management includes prior authorization of services, preauthorization of services, precertification
22 of services, post-service review, medical-necessity review, and benefits advisory;

23 (iii) Develop, maintain, and promote widespread adoption of a single, common website
24 where providers can obtain payors' preauthorization, benefits advisory, and preadmission
25 requirements;

26 (iv) Establish guidelines for payors to develop and maintain a website that providers can
27 use to request a preauthorization, including a prospective clinical necessity review; receive an
28 authorization number; and transmit an admission notification;

29 (v) Develop and implement the use of programs that implement selective prior
30 authorization requirements, based on stratification of healthcare providers' performance and
31 adherence to evidence-based medicine with the input of contracted healthcare providers and/or
32 provider organizations. Such criteria shall be transparent and easily accessible to contracted
33 providers. Such selective prior authorization programs shall be available when healthcare providers
34 participate directly with the insurer in risk-based payment contracts and may be available to

1 providers who do not participate in risk-based contracts;

2 (vi) Require the review of medical services, including behavioral health services, and
3 prescription drugs, subject to prior authorization on at least an annual basis, with the input of
4 contracted healthcare providers and/or provider organizations. Any changes to the list of medical
5 services, including behavioral health services, and prescription drugs requiring prior authorization,
6 shall be shared via provider-accessible websites;

7 (vii) Improve communication channels between health plans, healthcare providers, and
8 patients by:

9 (A) Requiring transparency and easy accessibility of prior authorization requirements,
10 criteria, rationale, and program changes to contracted healthcare providers and patients/health plan
11 enrollees which may be satisfied by posting to provider-accessible and member-accessible
12 websites; and

13 (B) Supporting:

14 (I) Timely submission by healthcare providers of the complete information necessary to
15 make a prior authorization determination, as early in the process as possible; and

16 (II) Timely notification of prior authorization determinations by health plans to impacted
17 health plan enrollees, and healthcare providers, including, but not limited to, ordering providers,
18 and/or rendering providers, and dispensing pharmacists which may be satisfied by posting to
19 provider-accessible websites or similar electronic portals or services;

20 (viii) Increase and strengthen continuity of patient care by:

21 (A) Defining protections for continuity of care during a transition period for patients
22 undergoing an active course of treatment, when there is a formulary or treatment coverage change
23 or change of health plan that may disrupt their current course of treatment and when the treating
24 physician determines that a transition may place the patient at risk; and for prescription medication
25 by allowing a grace period of coverage to allow consideration of referred health plan options or
26 establishment of medical necessity of the current course of treatment;

27 (B) Requiring continuity of care for medical services, including behavioral health services,
28 and prescription medications for patients on appropriate, chronic, stable therapy through
29 minimizing repetitive prior authorization requirements; and which for prescription medication shall
30 be allowed only on an annual review, with exception for labeled limitation, to establish continued
31 benefit of treatment; and

32 (C) Requiring communication between healthcare providers, health plans, and patients to
33 facilitate continuity of care and minimize disruptions in needed treatment which may be satisfied
34 by posting to provider-accessible websites or similar electronic portals or services;

1 (D) Continuity of care for formulary or drug coverage shall distinguish between FDA
2 designated interchangeable products and proprietary or marketed versions of a medication;

3 (ix) Encourage healthcare providers and/or provider organizations and health plans to
4 accelerate use of electronic prior authorization technology, including adoption of national standards
5 where applicable; and

6 (x) For the purposes of subsections (h)(3)(v) through (h)(3)(x) of this section, the
7 workgroup meeting may be conducted in part or whole through electronic methods.

8 (4) To provide a report to the house and senate, on or before January 1, 2017, with
9 recommendations for establishing guidelines and regulations for systems that give patients
10 electronic access to their claims information, particularly to information regarding their obligations
11 to pay for received medical services, pursuant to 45 C.F.R. § 164.524.

12 (5) No provision of this subsection (h) shall preclude the ongoing work of the office of
13 health insurance commissioner's administrative simplification task force, which includes meetings
14 with key stakeholders in order to improve, and provide recommendations regarding, the prior
15 authorization process.

16 (i) To issue an anti-cancer medication report. Not later than June 30, 2014, and annually
17 thereafter, the office of the health insurance commissioner (OHIC) shall provide the senate
18 committee on health and human services, and the house committee on corporations, with: (1)
19 Information on the availability in the commercial market of coverage for anti-cancer medication
20 options; (2) For the state employee's health benefit plan, the costs of various cancer-treatment
21 options; (3) The changes in drug prices over the prior thirty-six (36) months; and (4) Member
22 utilization and cost-sharing expense.

23 (j) To monitor the adequacy of each health plan's compliance with the provisions of the
24 federal Mental Health Parity Act, including a review of related claims processing and
25 reimbursement procedures. Findings, recommendations, and assessments shall be made available
26 to the public.

27 (k) To monitor the transition from fee-for-service and toward global and other alternative
28 payment methodologies for the payment for healthcare services. Alternative payment
29 methodologies should be assessed for their likelihood to promote access to affordable health
30 insurance, health outcomes, and performance.

31 (l) To report annually, no later than July 1, 2014, then biannually thereafter, on hospital
32 payment variation, including findings and recommendations, subject to available resources.

33 (m) Notwithstanding any provision of the general or public laws or regulation to the
34 contrary, provide a report with findings and recommendations to the president of the senate and the

1 speaker of the house, on or before April 1, 2014, including, but not limited to, the following
2 information:

3 (1) The impact of the current, mandated healthcare benefits as defined in §§ 27-18-48.1,
4 27-18-60, 27-18-62, 27-18-64, similar provisions in chapters 19, 20 and 41 of title 27, and §§ 27-
5 18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health
6 insurance for fully insured employers, subject to available resources;

7 (2) Current provider and insurer mandates that are unnecessary and/or duplicative due to
8 the existing standards of care and/or delivery of services in the healthcare system;

9 (3) A state-by-state comparison of health insurance mandates and the extent to which
10 Rhode Island mandates exceed other states benefits; and

11 (4) Recommendations for amendments to existing mandated benefits based on the findings
12 in (m)(1), (m)(2), and (m)(3) above.

13 (n) On or before July 1, 2014, the office of the health insurance commissioner, in
14 collaboration with the director of health and lieutenant governor's office, shall submit a report to
15 the general assembly and the governor to inform the design of accountable care organizations
16 (ACOs) in Rhode Island as unique structures for comprehensive healthcare delivery and value-
17 based payment arrangements, that shall include, but not be limited to:

18 (1) Utilization review;

19 (2) Contracting; and

20 (3) Licensing and regulation.

21 (o) On or before February 3, 2015, the office of the health insurance commissioner shall
22 submit a report to the general assembly and the governor that describes, analyzes, and proposes
23 recommendations to improve compliance of insurers with the provisions of § 27-18-76 with regard
24 to patients with mental health and substance use disorders.

25 (p) To work to ensure the health insurance coverage of behavioral health care under the
26 same terms and conditions as other health care, and to integrate behavioral health parity
27 requirements into the office of the health insurance commissioner insurance oversight and
28 healthcare transformation efforts.

29 (q) To work with other state agencies to seek delivery system improvements that enhance
30 access to a continuum of mental health and substance use disorder treatment in the state; and
31 integrate that treatment with primary and other medical care to the fullest extent possible.

32 (r) To direct insurers toward policies and practices that address the behavioral health needs
33 of the public and greater integration of physical and behavioral healthcare delivery.

34 (s) The office of the health insurance commissioner shall conduct an analysis of the impact

1 of the provisions of § 27-38.2-1(i) on health insurance premiums and access in Rhode Island and
2 submit a report of its findings to the general assembly on or before June 1, 2023.

3 (t) To undertake the analyses, reports, and studies contained in this section:

4 (1) The office shall hire the necessary staff and prepare a request for proposal for a qualified
5 and competent firm or firms to undertake the following analyses, reports, and studies:

6 (i) The firm shall undertake a comprehensive review of all social and human service
7 programs having a contract with or licensed by the state or any subdivision of the department of
8 children, youth and families (DCYF), the department of behavioral healthcare, developmental
9 disabilities and hospitals (BHDDH), the department of human services (DHS), the department of
10 health (DOH), and Medicaid for the purposes of:

11 (A) Establishing a baseline of the eligibility factors for receiving services;

12 (B) Establishing a baseline of the service offering through each agency for those
13 determined eligible;

14 (C) Establishing a baseline understanding of reimbursement rates for all social and human
15 service programs including rates currently being paid, the date of the last increase, and a proposed
16 model that the state may use to conduct future studies and analyses;

17 (D) Ensuring accurate and adequate reimbursement to social and human service providers
18 that facilitate the availability of high-quality services to individuals receiving home and
19 community-based long-term services and supports provided by social and human service providers;

20 (E) Ensuring the general assembly is provided accurate financial projections on social and
21 human service program costs, demand for services, and workforce needs to ensure access to entitled
22 beneficiaries and services;

23 (F) Establishing a baseline and determining the relationship between state government and
24 the provider network including functions, responsibilities, and duties;

25 (G) Determining a set of measures and accountability standards to be used by EOHHS and
26 the general assembly to measure the outcomes of the provision of services including budgetary
27 reporting requirements, transparency portals, and other methods; and

28 (H) Reporting the findings of human services analyses and reports to the speaker of the
29 house, senate president, chairs of the house and senate finance committees, chairs of the house and
30 senate health and human services committees, and the governor.

31 (2) The analyses, reports, and studies required pursuant to this section shall be
32 accomplished and published as follows and shall provide:

33 (i) An assessment and detailed reporting on all social and human service program rates to
34 be completed by January 1, 2023, including rates currently being paid and the date of the last

1 increase;

2 (ii) An assessment and detailed reporting on eligibility standards and processes of all
3 mandatory and discretionary social and human service programs to be completed by January 1,
4 2023;

5 (iii) An assessment and detailed reporting on utilization trends from the period of January
6 1, 2017, through December 31, 2021, for social and human service programs to be completed by
7 January 1, 2023;

8 (iv) An assessment and detailed reporting on the structure of the state government as it
9 relates to the provision of services by social and human service providers including eligibility and
10 functions of the provider network to be completed by January 1, 2023;

11 (v) An assessment and detailed reporting on accountability standards for services for social
12 and human service programs to be completed by January 1, 2023;

13 (vi) An assessment and detailed reporting by April 1, 2023, on all professional licensed
14 and unlicensed personnel requirements for established rates for social and human service programs
15 pursuant to a contract or established fee schedule;

16 (vii) An assessment and reporting on access to social and human service programs, to
17 include any wait lists and length of time on wait lists, in each service category by April 1, 2023;

18 (viii) An assessment and reporting of national and regional Medicaid rates in comparison
19 to Rhode Island social and human service provider rates by April 1, 2023;

20 (ix) An assessment and reporting on usual and customary rates paid by private insurers and
21 private pay for similar social and human service providers, both nationally and regionally, by April
22 1, 2023; and

23 (x) Completion of the development of an assessment and review process that includes the
24 following components: eligibility; scope of services; relationship of social and human service
25 provider and the state; national and regional rate comparisons and accountability standards that
26 result in recommended rate adjustments; and this process shall be completed by September 1, 2023,
27 and conducted biennially hereafter. The biennial rate setting shall be consistent with payment
28 requirements established in § 1902(a)(30)(A) of the Social Security Act, 42 U.S.C. §
29 1396a(a)(30)(A), and all federal and state law, regulations, and quality and safety standards. The
30 results and findings of this process shall be transparent, and public meetings shall be conducted to
31 allow providers, recipients, and other interested parties an opportunity to ask questions and provide
32 comment beginning in September 2023 and biennially thereafter.

33 (3) In fulfillment of the responsibilities defined in subsection (t), the office of the health
34 insurance commissioner shall consult with the Executive Office of Health and Human Services.

1 (u) Annually, each department (namely, EOHHS, DCYF, DOH, DHS, and BHDDH) shall
2 include the corresponding components of the assessment and review (i.e., eligibility; scope of
3 services; relationship of social and human service provider and the state; and national and regional
4 rate comparisons and accountability standards including any changes or substantive issues between
5 biennial reviews) including the recommended rates from the most recent assessment and review
6 with their annual budget submission to the office of management and budget and provide a detailed
7 explanation and impact statement if any rate variances exist between submitted recommended
8 budget and the corresponding recommended rate from the most recent assessment and review
9 process starting October 1, 2023, and biennially thereafter.

10 (v) The general assembly shall appropriate adequate funding as it deems necessary to
11 undertake the analyses, reports, and studies contained in this section relating to the powers and
12 duties of the office of the health insurance commissioner.

13 (w) The office of health insurance commission shall have oversight and enforcement
14 authority over the requirements of § 27-18.9-5 pursuant to the provisions of §§ 42-14-5(d) and 42-
15 14.5-3(e), including the power to require disclosure of information and documents, to clarify or
16 simplify appeals procedures, and to limit step therapy protocol use to ensure delivery of medically
17 necessary care, and to impose fines or other penalties for noncompliance.

18 SECTION 3. This act shall take effect upon passage.

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LC000446
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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO INSURANCE -- BENEFIT DETERMINATION AND UTILIZATION
REVIEW ACT

1 This act would limit the use by insurers of step therapy utilization management, a protocol
2 or program that establishes a specific sequence in which prescription drugs for a specified medical
3 condition are covered by an insurer by allowing medical providers to request step therapy
4 exceptions.

5 This act would take effect upon passage.

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