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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2016

A N A C T

RELATING TO HEALTH AND SAFETY - UTILIZATION REVIEW

Introduced By: Senator Roger Picard

Date Introduced: May 19, 2016

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Chapter 23-17.12 of the General Laws entitled "Health Care Services - Utilization Review Act" is hereby repealed in its entirety.

~~CHAPTER 23-17.12~~

~~Health Care Services - Utilization Review Act~~

~~**23-17.12-1. Purpose of chapter.** -- The purpose of the chapter is to:~~

~~(1) Promote the delivery of quality health care in a cost effective manner;~~

~~(2) Foster greater coordination between health care providers, patients, payors and utilization review entities;~~

~~(3) Protect patients, businesses, and providers by ensuring that review agents are qualified to perform utilization review activities and to make informed decisions on the appropriateness of medical care; and~~

~~(4) Ensure that review agents maintain the confidentiality of medical records in accordance with applicable state and federal laws.~~

~~**23-17.12-2. Definitions.** -- As used in this chapter, the following terms are defined as follows:~~

~~(1) "Adverse determination" means a utilization review decision by a review agent not to authorize a health care service. A decision by a review agent to authorize a health care service in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute an adverse determination if the review agent and provider are in agreement regarding the~~

~~decision. Adverse determinations include decisions not to authorize formulary and nonformulary medication.~~

~~(2) "Appeal" means a subsequent review of an adverse determination upon request by a patient or provider to reconsider all or part of the original decision.~~

~~(3) "Authorization" means the review agent's utilization review, performed according to subsection 23-17.12-2(20), concluded that the allocation of health care services of a provider, given or proposed to be given to a patient was approved or authorized.~~

~~(4) "Benefit determination" means a decision of the enrollee's entitlement to payment for covered health care services as defined in an agreement with the payor or its delegate.~~

~~(5) "Certificate" means a certificate of registration granted by the director to a review agent.~~

~~(6) "Complaint" means a written expression of dissatisfaction by a patient, or provider. The appeal of an adverse determination is not considered a complaint.~~

~~(7) "Concurrent assessment" means an assessment of the medical necessity and/or appropriateness of health care services conducted during a patient's hospital stay or course of treatment. If the medical problem is ongoing, this assessment may include the review of services after they have been rendered and billed. This review does not mean the elective requests for clarification of coverage or claims review or a provider's internal quality assurance program except if it is associated with a health care financing mechanism.~~

~~(8) "Department" means the department of health.~~

~~(9) "Director" means the director of the department of health.~~

~~(10) "Emergent health care services" has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42 as may be amended from time to time and includes those resources provided in the event of the sudden onset of a medical, mental health, or substance use or other health care condition manifesting itself by acute symptoms of a severity (e.g. severe pain) where the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part.~~

~~(11) "Patient" means an enrollee or participant in all hospital or medical plans seeking health care services and treatment from a provider.~~

~~(12) "Payor" means a health insurer, self insured plan, nonprofit health service plan, health insurance service organization, preferred provider organization, health maintenance organization or other entity authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state.~~

~~(13) "Practitioner" means any person licensed to provide or otherwise lawfully providing health care services, including, but not limited to, a physician, dentist, nurse, optometrist, podiatrist, physical therapist, clinical social worker, or psychologist.~~

~~(14) "Prospective assessment" means an assessment of the medical necessity and/or appropriateness of health care services prior to services being rendered.~~

~~(15) "Provider" means any health care facility, as defined in § 23-17-2 including any mental health and/or substance use treatment facility, physician, or other licensed practitioners identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.~~

~~(16) "Retrospective assessment" means an assessment of the medical necessity and/or appropriateness of health care services that have been rendered. This shall not include reviews conducted when the review agency has been obtaining ongoing information.~~

~~(17) "Review agent" means a person or entity or insurer performing utilization review that is either employed by, affiliated with, under contract with, or acting on behalf of:~~

~~(i) A business entity doing business in this state;~~

~~(ii) A party that provides or administers health care benefits to citizens of this state, including a health insurer, self-insured plan, non-profit health service plan, health insurance service organization, preferred provider organization or health maintenance organization authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state; or~~

~~(iii) A provider.~~

~~(18) "Same or similar specialty" means a practitioner who has the appropriate training and experience that is the same or similar as the attending provider in addition to experience in treating the same problems to include any potential complications as those under review.~~

~~(19) "Urgent health care services" has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42 as may be amended from time to time and includes those resources necessary to treat a symptomatic medical, mental health, or substance use or other health care condition requiring treatment within a twenty four (24) hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to be emergent health care services as defined in subdivision (10).~~

~~(20) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and/or appropriateness of the allocation of health care services of a provider, given or proposed to be given to a patient. Utilization review does not include:~~

~~(i) Elective requests for the clarification of coverage; or~~

~~(ii) Benefit determination; or~~

~~(iii) Claims review that does not include the assessment of the medical necessity and appropriateness; or~~

~~(iv) A provider's internal quality assurance program except if it is associated with a health care financing mechanism; or~~

~~(v) The therapeutic interchange of drugs or devices by a pharmacy operating as part of a licensed inpatient health care facility; or~~

~~(vi) The assessment by a pharmacist licensed pursuant to the provisions of chapter 19 of title 5 and practicing in a pharmacy operating as part of a licensed inpatient health care facility in the interpretation, evaluation and implementation of medical orders, including assessments and/or comparisons involving formularies and medical orders.~~

~~(21) "Utilization review plan" means a description of the standards governing utilization review activities performed by a private review agent.~~

~~(22) "Health care services" means and includes an admission, diagnostic procedure, therapeutic procedure, treatment, extension of stay, the ordering and/or filling of formulary or nonformulary medications, and any other services, activities, or supplies that are covered by the patient's benefit plan.~~

~~(23) "Therapeutic interchange" means the interchange or substitution of a drug with a dissimilar chemical structure within the same therapeutic or pharmacological class that can be expected to have similar outcomes and similar adverse reaction profiles when given in equivalent doses, in accordance with protocols approved by the president of the medical staff or medical director and the director of pharmacy.~~

~~23-17.12-3. General certificate requirements. --~~ ~~(a) A review agent shall not conduct utilization review in the state unless the department has granted the review agent a certificate.~~

~~(b) Individuals shall not be required to hold separate certification under this chapter when acting as either an employee of, an affiliate of, a contractor for, or otherwise acting on behalf of a certified review agent.~~

~~(c) The department shall issue a certificate to an applicant that has met the minimum standards established by this chapter, and regulations promulgated in accordance with it, including the payment of any fees as required, and other applicable regulations of the department.~~

~~(d) A certificate issued under this chapter is not transferable, and the transfer of fifty percent (50%) or more of the ownership of a review agent shall be deemed a transfer.~~

~~(e) After consultation with the payors and providers of health care, the department shall~~

~~adopt regulations necessary to implement the provisions of this chapter.~~

~~(f) The director of health is authorized to establish any fees for initial application, renewal applications, and any other administrative actions deemed necessary by the director to implement this chapter.~~

~~(g) The total cost of certification under this title shall be borne by the certified entities and shall be one hundred and fifty percent (150%) of the total salaries paid to the certifying personnel of the department engaged in those certifications less any salary reimbursements and shall be paid to the director to and for the use of the department. That assessment shall be in addition to any taxes and fees otherwise payable to the state.~~

~~(h) The application and other fees required under this chapter shall be sufficient to pay for the administrative costs of the certificate program and any other reasonable costs associated with carrying out the provisions of this chapter.~~

~~(i) A certificate expires on the second anniversary of its effective date unless the certificate is renewed for a two (2) year term as provided in this chapter.~~

~~(j) Any systemic changes in the review agents operations relative to certification information on file shall be submitted to the department for approval within thirty (30) days prior to implementation.~~

~~23-17.12-4. Application process.~~ ~~(a) An applicant requesting certification or recertification shall:~~

~~(1) Submit an application provided by the director; and~~

~~(2) Pay the application fee established by the director through regulation and § 23-17.12-3(f).~~

~~(b) The application shall:~~

~~(1) Be on a form and accompanied by supporting documentation that the director requires; and~~

~~(2) Be signed and verified by the applicant.~~

~~(c) Before the certificate expires, a certificate may be renewed for an additional two (2) years.~~

~~(d) If a completed application for recertification is being processed by the department, a certificate may be continued until a renewal determination is made.~~

~~(e) In conjunction with the application, the review agent shall submit information that the director requires including:~~

~~(1) A request that the state agency regard specific portions of the standards and criteria or the entire document to constitute "trade secrets" within the meaning of that term in § 38-2-~~

~~2(4)(i)(B);~~

~~(2) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;~~

~~(3) A copy of the materials used to inform enrollees of the requirements under the health benefit plan for seeking utilization review or pre-certification and their rights under this chapter, including information on appealing adverse determinations;~~

~~(4) A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan;~~

~~(5) A list of the third party payors and business entities for which the review agent is performing utilization review in this state and a brief description of the services it is providing for each client; and~~

~~(6) Evidence of liability insurance or of assets sufficient to cover potential liability.~~

~~(f) The information provided must demonstrate that the review agent will comply with the regulations adopted by the director under this chapter.~~

~~23-17.12-5. General application requirements.~~ ~~– An application for certification or recertification shall be accompanied by documentation to evidence the following:~~

~~(1) The requirement that the review agent provide patients and providers with a summary of its utilization review plan including a summary of the standards, procedures and methods to be used in evaluating proposed or delivered health care services;~~

~~(2) The circumstances, if any, under which utilization review may be delegated to any other utilization review program and evidence that the delegated agency is a certified utilization review agency delegated to perform utilization review pursuant to all of the requirements of this chapter;~~

~~(3) A complaint resolution process consistent with subsection 23-17.12-2(6) and acceptable to the department, whereby patients, their physicians, or other health care providers may seek resolution of complaints and other matters of which the review agent has received written notice;~~

~~(4) The type and qualifications of personnel (employed or under contract) authorized to perform utilization review, including a requirement that only a practitioner with the same license status as the ordering practitioner, or a licensed physician or dentist, is permitted to make a prospective or concurrent adverse determination;~~

~~(5) The requirement that a representative of the review agent is reasonably accessible to patients, patient's family and providers at least five (5) days a week during normal business in Rhode Island and during the hours of the agency's review operations;~~

~~(6) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;~~

~~(7) The policies and procedures regarding the notification and conduct of patient interviews by the review agent;~~

~~(8) The requirement that no employee of, or other individual rendering an adverse determination for, a review agent may receive any financial incentives based upon the number of denials of certification made by that employee or individual;~~

~~(9) The requirement that the utilization review agent shall not impede the provision of health care services for treatment and/or hospitalization or other use of a provider's services or facilities for any patient;~~

~~(10) Evidence that the review agent has not entered into a compensation agreement or contract with its employees or agents whereby the compensation of its employees or its agents is based upon a reduction of services or the charges for those services, the reduction of length of stay, or utilization of alternative treatment settings; provided, nothing in this chapter shall prohibit agreements and similar arrangements; and~~

~~(11) An adverse determination and internal appeals process consistent with § 23-17.12-9 and acceptable to the department, whereby patients, their physicians, or other health care providers may seek prompt reconsideration or appeal of adverse determinations by the review agent.~~

~~23-17.12-6. Denial, suspension, or revocation of certificate.~~ ~~(a) The department may deny a certificate upon review of the application if, upon review of the application, it finds that the applicant proposing to conduct utilization review does not meet the standards required by this chapter or by any regulations promulgated pursuant to this chapter.~~

~~(b) The department may revoke a certificate and/or impose reasonable monetary penalties not to exceed five thousand dollars ($5,000) per violation in any case in which:~~

~~(1) The review agent fails to comply substantially with the requirements of this chapter or of regulations adopted pursuant to this chapter;~~

~~(2) The review agent fails to comply with the criteria used by it in its application for a certificate; or~~

~~(3) The review agent refuses to permit examination by the director to determine compliance with the requirements of this chapter and regulations promulgated pursuant to the authority granted to the director in this chapter; provided, however, that the examination shall be subject to the confidentiality and "need to know" provisions of subdivisions 23-17.12-9(c)(4) and (5). These determinations may involve consideration of any written grievances filed with the~~

department against the review agent by patients or providers.

(c) Any applicant or certificate holder aggrieved by an order or a decision of the department made under this chapter without a hearing may, within thirty (30) days after notice of the order or decision, make a written request to the department for a hearing on the order or decision pursuant to § 42-35-15.

(d) The procedure governing hearings authorized by this section shall be in accordance with §§ 42-35-9 -- 42-35-13 as stipulated in § 42-35-14(a). A full and complete record shall be kept of all proceedings, and all testimony shall be recorded but need not be transcribed unless the decision is appealed pursuant to § 42-35-15. A copy or copies of the transcript may be obtained by any interested party upon payment of the cost of preparing the copy or copies. Witnesses may be subpoenaed by either party.

23-17.12-7. Judicial review. -- Any person who has exhausted all administrative remedies available to him or her within the department, and who is aggrieved by a final decision of the department under § 23-17.12-6, is entitled to judicial review pursuant to §§ 42-35-15 and 42-35-16.

23-17.12-8. Waiver of requirements. -- (a) Except for utilization review agencies performing utilization review activities to determine the necessity and/or appropriateness of substance use and mental health care, treatment or services, the department shall waive all the requirements of this chapter, with the exception of those contained in §§ 23-17.12-9, (a)(1)-(3), (5), (6), (8), (b)(1)-(6), and (c)(2)-(6), 23-17.12-12, and 23-17.12-14, for a review agent that has received, maintains and provides evidence to the department of accreditation from the utilization review accreditation commission (URAC) or other organization approved by the director. The waiver shall be applicable only to those services that are included under the accreditation by the utilization review accreditation commission or other approved organization.

(b) The department shall waive the requirements of this chapter only when a direct conflict exists with those activities of a review agent that are conducted pursuant to contracts with the state or the federal government or those activities under other state or federal jurisdictions.

(c) The limitation in subsection 23-17.12-8(b) notwithstanding, the department may waive or exempt all or part of the requirements of this chapter by mutual written agreement with a state department or agency when such waiver or exemption is determined to be necessary and appropriate to the administration of a health care related program. The department shall promulgate such regulations as deemed appropriate to implement this provision.

23-17.12-8.1. Variance of statutory requirements.. -- (a) The department is authorized to issue a statutory variance from one or more of the specific requirements of this chapter to a

~~review agent where it determines that such variance is necessary to permit the review agent to evaluate and address practitioner billing and practice patterns when the review agent believes in good faith that such patterns evidence the existence of fraud or abuse. Any variance issued by the department pursuant to this section shall be limited in application to those services billed directly by the practitioner. Prior to issuing a statutory variance the department shall provide notice and a public hearing to ensure necessary patient and health care provider protections in the process. Statutory variances shall be issued for a period not to exceed one year and may be subject to such terms and conditions deemed necessary by the department.~~

~~(b) On or before January 15th of each year, the department shall issue a report to the general assembly summarizing any review agent activity as a result of a waiver granted under the provisions of this section.~~

~~23-17.12-9. Review agency requirement for adverse determination and internal appeals.~~ ~~(a) The adverse determination and appeals process of the review agent shall conform to the following:~~

~~(1) Notification of a prospective adverse determination by the review agent shall be mailed or otherwise communicated to the provider of record and to the patient or other appropriate individual as follows:~~

~~(i) Within fifteen (15) business days of receipt of all the information necessary to complete a review of non-urgent and/or non-emergent services;~~

~~(ii) Within seventy-two (72) hours of receipt of all the information necessary to complete a review of urgent and/or emergent services; and~~

~~(iii) Prior to the expected date of service.~~

~~(2) Notification of a concurrent adverse determination shall be mailed or otherwise communicated to the patient and to the provider of record period as follows:~~

~~(i) To the provider(s) prior to the end of the current certified period; and~~

~~(ii) To the patient within one business day of making the adverse determination.~~

~~(3) Notification of a retrospective adverse determination shall be mailed or otherwise communicated to the patient and to the provider of record within thirty (30) business days of receipt of a request for payment with all supporting documentation for the covered benefit being reviewed.~~

~~(4) A utilization review agency shall not retrospectively deny authorization for health care services provided to a covered person when an authorization has been obtained for that service from the review agent unless the approval was based upon inaccurate information material to the review or the health care services were not provided consistent with the provider's~~

~~submitted plan of care and/or any restrictions included in the prior approval granted by the review agent.~~

~~(5) Any notice of an adverse determination shall include:~~

~~(i) The principal reasons for the adverse determination, to include explicit documentation of the criteria not met and/or the clinical rationale utilized by the agency's clinical reviewer in making the adverse determination. The criteria shall be in accordance with the agency criteria noted in subsection 23-17.12-9(d) and shall be made available within the first level appeal timeframe if requested unless otherwise provided as part of the adverse determination notification process;~~

~~(ii) The procedures to initiate an appeal of the adverse determination, including the name and telephone number of the person to contract with regard to an appeal;~~

~~(iii) The necessary contact information to complete the two-way direct communication defined in subdivision 23-17.12-9(a)(7); and~~

~~(iv) The information noted in subdivision 23-27.12-9(a)(5)(i)(ii)(iii) for all verbal notifications followed by written notification to the patient and provider(s).~~

~~(6) All initial retrospective adverse determinations of a health care service that had been ordered by a physician, dentist or other practitioner shall be made, documented and signed consistent with the regulatory requirements which shall be developed by the department with the input of review agents, providers and other affected parties.~~

~~(7) A level one appeal decision of an adverse determination shall not be made until an appropriately qualified and licensed review physician, dentist or other practitioner has spoken to, or otherwise provided for, an equivalent two-way direct communication with the patient's attending physician, dentist, other practitioner, other designated or qualified professional or provider responsible for treatment of the patient concerning the medical care, with the exception of the following:~~

~~(i) When the attending provider is not reasonably available;~~

~~(ii) When the attending provider chooses not to speak with agency staff;~~

~~(iii) When the attending provider has negotiated an agreement with the review agent for alternative care; and/or~~

~~(iv) When the attending provider requests a peer to peer communication prior to the adverse determination, the review agency shall then comply with subdivision 23-17.12-9(c)(1) in responding to such a request. Such requests shall be on the case specific basis unless otherwise arranged for in advance by the provider.~~

~~(8) All initial, prospective and concurrent adverse determinations of a health care service~~

~~that had been ordered by a physician, dentist or other practitioner shall be made, documented and signed by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician or dentist. This does not prohibit appropriately qualified review agency staff from engaging in discussions with the attending provider, the attending provider's designee or appropriate health care facility and office personnel regarding alternative service and treatment options. Such a discussion shall not constitute an adverse determination provided though that any change to the provider's original order and/or any decision for an alternative level of care must be made and/or appropriately consented to by the attending provider or the provider's designee responsible for treating the patient.~~

~~(9) The requirement that, upon written request made by or on behalf of a patient, any adverse determination and/or appeal shall include the written evaluation and findings of the reviewing physician, dentist or other practitioner. The review agent is required to accept a verbal request made by or on behalf of a patient for any information where a provider or patient can demonstrate that a timely response is urgent.~~

~~(b) The review agent shall conform to the following for the appeal of an adverse determination:~~

~~(1) The review agent shall maintain and make available a written description of the appeal procedure by which either the patient or the provider of record may seek review of determinations not to authorize a health care service. The process established by each review agent may include a reasonable period within which an appeal must be filed to be considered and that period shall not be less than sixty (60) days.~~

~~(2) The review agent shall notify, in writing, the patient and provider of record of its decision on the appeal as soon as practical, but in no case later than fifteen (15) or twenty-one (21) business days if verbal notice is given within fifteen (15) business days after receiving the required documentation on the appeal.~~

~~(3) The review agent shall also provide for an expedited appeals process for emergency or life threatening situations. Each review agent shall complete the adjudication of expedited appeals within two (2) business days of the date the appeal is filed and all information necessary to complete the appeal is received by the review agent.~~

~~(4) All first level appeals of determinations not to authorize a health care service that had been ordered by a physician, dentist, or other practitioner shall be made, documented, and signed by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician or a licensed dentist.~~

~~(5) All second level appeal decisions shall be made, signed, and documented by a~~

~~licensed practitioner in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion.~~

~~(6) The review agent shall maintain records of written appeals and their resolution, and shall provide reports as requested by the department.~~

~~(c) The review agency must conform to the following requirements when making its adverse determination and appeal decisions:~~

~~(1) The review agent must assure that the licensed practitioner or licensed physician is reasonably available to review the case as required under subdivision 23-17.12-9(a)(7) and shall conform to the following:~~

~~(i) Each agency peer reviewer shall have access to and review all necessary information as requested by the agency and/or submitted by the provider(s) and/or patients;~~

~~(ii) Each agency shall provide accurate peer review contact information to the provider at the time of service, if requested, and/or prior to such service, if requested. This contact information must provide a mechanism for direct communication with the agency's peer reviewer;~~

~~(iii) Agency peer reviewers shall respond to the provider's request for a two-way direct communication defined in subdivision 23-17.12-9(a)(7)(iv) as follows:~~

~~(A) For a prospective review of non-urgent and non-emergent health care services, a response within one business day of the request for a peer discussion;~~

~~(B) For concurrent and prospective reviews of urgent and emergent health care services, a response within a reasonable period of time of the request for a peer discussion; and~~

~~(C) For retrospective reviews, prior to the first level appeal decision.~~

~~(iv) The review agency will have met the requirements of a two-way direct communication, when requested and/or as required prior to the first level of appeal, when it has made two (2) reasonable attempts to contact the attending provider directly.~~

~~(v) Repeated violations of this section shall be deemed to be substantial violations pursuant to § 23-17.12-14 and shall be cause for the imposition of penalties under that section.~~

~~(2) No reviewer at any level under this section shall be compensated or paid a bonus or incentive based on making or upholding an adverse determination.~~

~~(3) No reviewer under this section who has been involved in prior reviews of the case under appeal or who has participated in the direct care of the patient may participate as the sole reviewer in reviewing a case under appeal; provided, however, that when new information has been made available at the first level of appeal, then the review may be conducted by the same reviewer who made the initial adverse determination.~~

~~(4) A review agent is only entitled to review information or data relevant to the utilization review process. A review agent may not disclose or publish individual medical records or any confidential medical information obtained in the performance of utilization review activities. A review agent shall be considered a third party health insurer for the purposes of § 5-37.3-6(b)(6) of this state and shall be required to maintain the security procedures mandated in § 5-37.3-4(c).~~

~~(5) Notwithstanding any other provision of law, the review agent, the department, and all other parties privy to information which is the subject of this chapter shall comply with all state and federal confidentiality laws, including, but not limited to, chapter 37.3 of title 5 (Confidentiality of Health Care Communications and Information Act) and specifically § 5-37.3-4(c), which requires limitation on the distribution of information which is the subject of this chapter on a "need to know" basis, and § 40.1-5-26.~~

~~(6) The department may, in response to a complaint that is provided in written form to the review agent, review an appeal regarding any adverse determination, and may request information of the review agent, provider or patient regarding the status, outcome or rationale regarding the decision.~~

~~(d) The requirement that each review agent shall utilize and provide upon request, by Rhode Island licensed hospitals and the Rhode Island Medical Society, in either electronic or paper format, written medically acceptable screening criteria and review procedures which are established and periodically evaluated and updated with appropriate consultation with Rhode Island licensed physicians, hospitals, including practicing physicians, and other health care providers in the same specialty as would typically treat the services subject to the criteria as follows:~~

~~(1) Utilization review agents shall consult with no fewer than five (5) Rhode Island licensed physicians or other health care providers. Further, in instances where the screening criteria and review procedures are applicable to inpatients and/or outpatients of hospitals, the medical director of each licensed hospital in Rhode Island shall also be consulted. Utilization review agents who utilize screening criteria and review procedures provided by another entity may satisfy the requirements of this section if the utilization review agent demonstrates to the satisfaction of the director that the entity furnishing the screening criteria and review procedures has complied with the requirements of this section.~~

~~(2) Utilization review agents seeking initial certification shall conduct the consultation for all screening and review criteria to be utilized. Utilization review agents who have been certified for one year or longer shall be required to conduct the consultation on a periodic basis~~

~~for the utilization review agent's highest volume services subject to utilization review during the prior year; services subject to the highest volume of adverse determinations during the prior year; and for any additional services identified by the director.~~

~~(3) Utilization review agents shall not include in the consultations as required under paragraph (1) of this subdivision, any physicians or other health services providers who have financial relationships with the utilization review agent other than financial relationships for provisions of direct patient care to utilization review agent enrollees and reasonable compensation for consultation as required by paragraph (1) of this subdivision.~~

~~(4) All documentation regarding required consultations, including comments and/or recommendations provided by the health care providers involved in the review of the screening criteria, as well as the utilization review agent's action plan or comments on any recommendations, shall be in writing and shall be furnished to the department on request. The documentation shall also be provided on request to any licensed health care provider at a nominal cost that is sufficient to cover the utilization review agent's reasonable costs of copying and mailing.~~

~~(5) Utilization review agents may utilize non-Rhode Island licensed physicians or other health care providers to provide the consultation as required under paragraph (1) of this subdivision, when the utilization review agent can demonstrate to the satisfaction of the director that the related services are not currently provided in Rhode Island or that another substantial reason requires such approach.~~

~~(6) Utilization review agents whose annualized data reported to the department demonstrate that the utilization review agent will review fewer than five hundred (500) such requests for authorization may request a variance from the requirements of this section.~~

~~**23-17.12-10. External appeal requirements. --** (a) In cases where the second level of appeal to reverse an adverse determination is unsuccessful, the review agent shall provide for an external appeal by an unrelated and objective appeal agency, selected by the director. The director shall promulgate rules and regulations including, but not limited to, criteria for designation, operation, policy, oversight, and termination of designation as an external appeal agency. The external appeal agency shall not be required to be certified under this chapter for activities conducted pursuant to its designation.~~

~~(b) The external appeal shall have the following characteristics:~~

~~(1) The external appeal review and decision shall be based on the medical necessity for the health care or service and the appropriateness of service delivery for which authorization has been denied.~~

~~(2) Neutral physicians, dentists, or other practitioners in the same or similar general specialty as typically manages the health care service shall be utilized to make the external appeal decisions.~~

~~(3) Neutral physicians, dentists, or other practitioners shall be selected from lists:~~

~~(i) Mutually agreed upon by the provider associations, insurers, and the purchasers of health services; and~~

~~(ii) Used during a twelve (12) month period as the source of names for neutral physician, dentist, or other practitioner reviewers.~~

~~(4) The neutral physician, dentist, or other practitioner may confer either directly with the review agent and provider, or with physicians or dentists appointed to represent them.~~

~~(5) Payment for the appeal fee charged by the neutral physician, dentist, or other practitioner shall be shared equally between the two (2) parties to the appeal; provided, however, that if the decision of the utilization review agent is overturned, the appealing party shall be reimbursed by the utilization review agent for their share of the appeal fee paid under this subsection.~~

~~(6) The decision of the external appeal agency shall be binding; however, any person who is aggrieved by a final decision of the external appeal agency is entitled to judicial review in a court of competent jurisdiction.~~

~~**23-17.12-11. Repealed.**~~

~~**23-17.12-12. Reporting requirements.**~~ ~~(a) The department shall establish reporting requirements to determine if the utilization review programs are in compliance with the provisions of this chapter and applicable regulations.~~

~~(b) By November 14, 2014, the department shall report to the general assembly regarding hospital admission practices and procedures and the effects of such practices and procedures on the care and wellbeing of patients who present behavioral healthcare conditions on an emergency basis. The report shall be developed with the cooperation of the department of behavioral healthcare, developmental disabilities, and hospitals and of the department of children, youth, and families, and shall recommend changes to state law and regulation to address any necessary and appropriate revisions to the department's regulations related to utilization review based on the Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Patient Protection and Affordable Care Act, Pub. L. 111-148, and the state's regulatory interpretation of parity in insurance coverage of behavioral healthcare. These recommended or adopted revisions to the department's regulations shall include, but not be limited to:~~

~~(1) Adverse determination and internal appeals, with particular regard to the time~~

~~necessary to complete a review of urgent and/or emergent services for patients with behavioral health needs;~~

~~(2) External appeal requirements;~~

~~(3) The process for investigating whether insurers and agents are complying with the provisions of chapter 17.12 of title 23 in light of parity in insurance coverage for behavioral healthcare, with particular regard to emergency admissions; and~~

~~(4) Enforcement of the provisions of chapter 17.12 of title 23 in light of insurance parity for behavioral healthcare.~~

~~**23-17.12-13. Lists. --** The director shall periodically provide a list of private review agents issued certificates and the renewal date for those certificates to all licensed health care facilities and any other individual or organization requesting the list.~~

~~**23-17.12-14. Penalties. --** A person who substantially violates any provision of this chapter or any regulation adopted under this chapter or who submits any false information in an application required by this chapter is guilty of a misdemeanor and on conviction is subject to a penalty not exceeding five thousand dollars ($5,000).~~

~~**23-17.12-15. Annual report. --** The director shall issue an annual report to the governor and the general assembly concerning the conduct of utilization review in the state. The report shall include a description of utilization programs and the services they provide, an analysis of complaints filed against private review agents by patients or providers and an evaluation of the impact of utilization review programs on patient access to care.~~

~~**23-17.12-16. Fees. --** The proceeds of any fees, monetary penalties, and fines collected pursuant to the provisions of this chapter shall be deposited as general revenues.~~

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~~**23-17.12-17. Severability. --** If any provision of this chapter or the application of any provision to any person or circumstance shall be held invalid, that invalidity shall not affect the provisions or application of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.~~

SECTION 2. Chapter 23-17.13 of the General Laws entitled "Health Care Accessibility and Quality Assurance Act" is hereby repealed in its entirety.

~~CHAPTER 23-17.13~~

~~Health Care Accessibility and Quality Assurance Act~~

~~**23-17.13-1. Purpose. --** The legislature declares that:~~

~~(1) It is in the best interest of the public that those individuals and care entities involved with the delivery of plan coverage in our state meet the standards of this chapter to insure~~

accessibility and quality for the state's patients;

(2) Nothing in the legislation is intended to prohibit a health care entity or contractor from forming limited networks of providers; and

(3) It is a vital state function to establish these standards for the conduct of health plans by a health care entity in Rhode Island.

23-17.13-2. Definitions. — As used in this chapter:

(1) "Adverse decision" means any decision by a review agent not to certify an admission, service, procedure, or extension of stay. A decision by a reviewing agent to certify an admission, service, or procedure in an alternative treatment setting, or to certify a modified extension of stay, shall not constitute an adverse decision if the reviewing agent and the requesting provider are in agreement regarding the decision.

(2) "Contractor" means a person/entity that:

(i) Establishes, operates or maintains a network of participating providers;

(ii) Contracts with an insurance company, a hospital or medical or dental service plan, an employer, whether under written or self insured, an employee organization, or any other entity providing coverage for health care services to administer a plan; and/or

(iii) Conducts or arranges for utilization review activities pursuant to chapter 17.12 of this title.

(3) "Direct service ratio" means the amount of premium dollars expended by the plan for covered services provided to enrollees on a plan's fiscal year basis.

(4) "Director" means the director of the department of health.

(5) "Emergency services" has the same meaning as the meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42, as may be amended from time to time, and includes the sudden onset of a medical or mental condition that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily organ or part.

(6) "Health care entity" means a licensed insurance company, hospital, or dental or medical service plan or health maintenance organization, or a contractor as described in subdivision (2), that operates a health plan.

(7) "Health care services" includes, but is not limited to, medical, mental health, substance use, and dental services.

(8) "Health plan" means a plan operated by a health care entity as described in subdivision (6) that provides for the delivery of care services to persons enrolled in the plan

through:

(i) Arrangements with selected providers to furnish health care services; and/or

(ii) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan.

(9) "Provider" means a physician, hospital, pharmacy, laboratory, dentist, or other state licensed or other state recognized provider of health care services or supplies, and whose services are recognized pursuant to 213(d) of the Internal Revenue Code, 26 U.S.C. § 213(d), that has entered into an agreement with a health care entity as described in subdivision (6) or contractor as described in subdivision (2) to provide these services or supplies to a patient enrolled in a plan.

(10) "Provider incentive plan" means any compensation arrangement between a health care entity or plan and a provider or provider group that may directly or indirectly have the effect of reducing or limiting services provided with respect to an individual enrolled in a plan.

(11) "Qualified health plan" means a plan that the director of the department of health certified, upon application by the program, as meeting the requirements of this chapter.

(12) "Qualified utilization review program" means utilization review program that meets the requirements of chapter 17.12 of this title.

(13) "Most favored rate clause" means a provision in a provider contract whereby the rates or fees to be paid by a health plan are fixed, established or adjusted to be equal to or lower than the rates or fees paid to the provider by any other health plan or third party payor.

23-17.13-3. Certification of health plans. — (a) Certification process.

(1) Certification.

(i) The director shall establish a process for certification of health plans meeting the requirements of certification in subsection (b).

(ii) The director shall act upon the health plan's completed application for certification within ninety (90) days of receipt of such application for certification.

(2) Review and recertification. - To ensure compliance with subsection (b), the director shall establish procedures for the periodic review and recertification of qualified health plans not less than every five (5) years; provided, however, that the director may review the certification of a qualified health plan at any time if there exists evidence that a qualified health plan may be in violation of subsection (b).

(3) Cost of certification. - The total cost of obtaining and maintaining certification under this title and compliance with the requirements of the applicable rules and regulations are borne by the entities so certified and shall be one hundred and fifty percent (150%) of the total salaries paid to the certifying personnel of the department engaged in those certifications less any salary

~~reimbursements and shall be paid to the director to and for the use of the department. That assessment shall be in addition to any taxes and fees otherwise payable to the state.~~

~~(4) Standard definitions. To help ensure a patient's ability to make informed decisions regarding their health care, the director shall promulgate regulation(s) to provide for standardized definitions (unless defined in existing statute) of the following terms in this subdivision, provided, however, that no definition shall be construed to require a health care entity to add any benefit, to increase the scope of any benefit, or to increase any benefit under any contract:~~

~~(i) Allowable charge;~~

~~(ii) Capitation;~~

~~(iii) Co-payments;~~

~~(iv) Co-insurance;~~

~~(v) Credentialing;~~

~~(vi) Formulary;~~

~~(vii) Grace period;~~

~~(viii) Indemnity insurance;~~

~~(ix) In-patient care;~~

~~(x) Maximum lifetime cap;~~

~~(xi) Medical necessity;~~

~~(xii) Out-of-network;~~

~~(xiii) Out-patient;~~

~~(xiv) Pre-existing conditions;~~

~~(xv) Point of service;~~

~~(xvi) Risk sharing;~~

~~(xvii) Second opinion;~~

~~(xviii) Provider network;~~

~~(xix) Urgent care.~~

~~(b) Requirements for certification. The director shall establish standards and procedures for the certification of qualified health plans that conduct business in this state and who have demonstrated the ability to ensure that health care services will be provided in a manner to assure availability and accessibility, adequate personnel and facilities, and continuity of service, and has demonstrated arrangements for ongoing quality assurance programs regarding care processes and outcomes; other standards shall consist of, but are not limited to, the following:~~

~~(1) Prospective and current enrollees in health plans must be provided information as to the terms and conditions of the plan consistent with the rules and regulations promulgated under~~

~~chapter 12.3 of title 42 so that they can make informed decisions about accepting and utilizing the health care services of the health plan. This must be standardized so that customers can compare the attributes of the plans, and all information required by this paragraph shall be updated at intervals determined by the director. Of those items required under this section, the director shall also determine which items shall be routinely distributed to prospective and current enrollees as listed in this subsection and which items may be made available upon request. The items to be disclosed are:~~

~~(i) Coverage provisions, benefits, and any restriction or limitations on health care services, including but not limited to, any exclusions as follows: by category of service, and if applicable, by specific service, by technology, procedure, medication, provider or treatment modality, diagnosis and condition, the latter three (3) of which shall be listed by name.~~

~~(ii) Experimental treatment modalities that are subject to change with the advent of new technology may be listed solely by the broad category "Experimental Treatments". The information provided to consumers shall include the plan's telephone number and address where enrollees may call or write for more information or to register a complaint regarding the plan or coverage provision.~~

~~(2) Written statement of the enrollee's right to seek a second opinion, and reimbursement if applicable.~~

~~(3) Written disclosure regarding the appeals process described in § 23-17.12-1 et seq. and in the rules and regulations for the utilization review of care services, promulgated by the department of health, the telephone numbers and addresses for the plan's office which handles complaints as well as for the office which handles the appeals process under § 23-17.12-1 et seq. and the rules and regulations for the utilization of health.~~

~~(4) Written statement of prospective and current enrollees' right to confidentiality of all health care record and information in the possession and/or control of the plan, its employees, its agents and parties with whom a contractual agreement exists to provide utilization review or who in any way have access to care information. A summary statement of the measures taken by the plan to ensure confidentiality of an individual's health care records shall be disclosed.~~

~~(5) Written disclosure of the enrollee's right to be free from discrimination by the health plan and the right to refuse treatment without jeopardizing future treatment.~~

~~(6) Written disclosure of a plan's policy to direct enrollees to particular providers. Any limitations on reimbursement should the enrollee refuse the referral must be disclosed.~~

~~(7) A summary of prior authorization or other review requirements including preauthorization review, concurrent review, post-service review, post-payment review and any~~

~~procedure that may lead the patient to be denied coverage for or not be provided a particular service.~~

~~(8) Any health plan that operates a provider incentive plan shall not enter into any compensation agreement with any provider of covered services or pharmaceutical manufacturer pursuant to which specific payment is made directly or indirectly to the provider as an inducement or incentive to reduce or limit services, to reduce the length of stay or the use of alternative treatment settings or the use of a particular medication with respect to an individual patient, provided however, that capitation agreements and similar risk sharing arrangements are not prohibited.~~

~~(9) Health plans must disclose to prospective and current enrollees the existence of financial arrangements for capitated or other risk sharing arrangements that exist with providers in a manner described in paragraphs (i), (ii), and (iii):~~

~~(i) "This health plan utilizes capitated arrangements, with its participating providers, or contains other similar risk sharing arrangements;~~

~~(ii) This health plan may include a capitated reimbursement arrangement or other similar risk sharing arrangement, and other financial arrangements with your provider;~~

~~(iii) This health plan is not capitated and does not contain other risk sharing arrangements."~~

~~(10) Written disclosure of criteria for accessing emergency health care services as well as a statement of the plan's policies regarding payment for examinations to determine if emergency health care services are necessary, the emergency care itself, and the necessary services following emergency treatment or stabilization. The health plan must respond to the request of the treating provider for post-stabilization treatment by approving or denying it as soon as possible.~~

~~(11) Explanation of how health plan limitations impact enrollees, including information on enrollee financial responsibility for payment for co-insurance, co-payment, or other non-covered, out-of-pocket, or out-of-plan services. This shall include information on deductibles and benefits limitations including, but not limited to, annual limits and maximum lifetime benefits.~~

~~(12) The terms under which the health plan may be renewed by the plan enrollee, including any reservation by the plan of any right to increase premiums.~~

~~(13) Summary of criteria used to authorize treatment.~~

~~(14) A schedule of revenues and expenses, including direct service ratios and other statistical information which meets the requirements set forth below on a form prescribed by the director.~~

~~(15) Plan costs of health care services, including but not limited to all of the following:~~

~~(i) Physician services;~~

~~(ii) Hospital services, including both inpatients and outpatient services;~~

~~(iii) Other professional services;~~

~~(iv) Pharmacy services, excluding pharmaceutical products dispensed in a physician's office;~~

~~(v) Health education;~~

~~(vi) Substance use services and mental health services.~~

~~(16) Plan complaint, adverse decision, and prior authorization statistics. This statistical data shall be updated annually:~~

~~(i) The ratio of the number of complaints received to the total number of covered persons, reported by category, listed in paragraphs (b)(15)(i) – (vi);~~

~~(ii) The ratio of the number of adverse decisions issued to the number of complaints received, reported by category;~~

~~(iii) The ratio of the number of prior authorizations denied to the number of prior authorizations requested, reported by category;~~

~~(iv) The ratio of the number of successful enrollee appeals to the total number of appeals filed.~~

~~(17) Plans must demonstrate that:~~

~~(i) They have reasonable access to providers, so that all covered health care services will be provided. This requirement cannot be waived and must be met in all areas where the health plan has enrollees;~~

~~(ii) Urgent health care services, if covered, shall be available within a time frame that meets standards set by the director.~~

~~(18) A comprehensive list of participating providers listed by office location, specialty if applicable, and other information as determined by the director, updated annually.~~

~~(19) Plans must provide to the director, at intervals determined by the director, enrollee satisfaction measures. The director is authorized to specify reasonable requirements for these measures consistent with industry standards to assure an acceptable degree of statistical validity and comparability of satisfaction measures over time and among plans. The director shall publish periodic reports for the public providing information on health plan enrollee satisfaction.~~

~~(c) Issuance of certification.~~

~~(1) Upon receipt of an application for certification, the director shall notify and afford the public an opportunity to comment upon the application.~~

~~(2) A health care plan will meet the requirements of certification, subsection (b) by providing information required in subsection (b) to any state or federal agency in conformance with any other applicable state or federal law, or in conformity with standards adopted by an accrediting organization provided that the director determines that the information is substantially similar to the previously mentioned requirements and is presented in a format that provides a meaningful comparison between health plans.~~

~~(3) All health plans shall be required to establish a mechanism, under which providers, including local providers participating in the plan, provide input into the plan's health care policy, including technology, medications and procedures, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures.~~

~~(4) All health plans shall be required to establish a mechanism under which local individual subscribers to the plan provide input into the plan's procedures and processes regarding the delivery of health care services.~~

~~(5) A health plan shall not refuse to contract with or compensate for covered services an otherwise eligible provider or non-participating provider solely because that provider has in good faith communicated with one or more of his or her patients regarding the provisions, terms or requirements of the insurer's products as they relate to the needs of that provider's patients.~~

~~(6) (i) All health plans shall be required to publicly notify providers within the health plans' geographic service area of the opportunity to apply for credentials. This notification process shall be required only when the plan contemplates adding additional providers and may be specific as to geographic area and provider specialty. Any provider not selected by the health plan may be placed on a waiting list.~~

~~(ii) This credentialing process shall begin upon acceptance of an application from a provider to the plan for inclusion.~~

~~(iii) Each application shall be reviewed by the plan's credentialing body.~~

~~(iv) All health plans shall develop and maintain credentialing criteria to be utilized in adding providers from the plans' network. Credentialing criteria shall be based on input from providers credentialed in the plan and these standards shall be available to applicants. When economic considerations are part of the decisions, the criteria must be available to applicants. Any economic profiling must factor the specialty utilization and practice patterns and general information comparing the applicant to his or her peers in the same specialty will be made available. Any economic profiling of providers must be adjusted to recognize case mix, severity of illness, age of patients and other features of a provider's practice that may account for higher than or lower than expected costs. Profiles must be made available to those so profiled.~~

~~(7) A health plan shall not exclude a provider of covered services from participation in its provider network based solely on:~~

~~(i) The provider's degree or license as applicable under state law; or~~

~~(ii) The provider of covered services lack of affiliation with, or admitting privileges at a hospital, if that lack of affiliation is due solely to the provider's type of license.~~

~~(8) Health plans shall not discriminate against providers solely because the provider treats a substantial number of patients who require expensive or uncompensated medical care.~~

~~(9) The applicant shall be provided with all reasons used if the application is denied.~~

~~(10) Plans shall not be allowed to include clauses in physician or other provider contracts that allow for the plan to terminate the contract "without cause"; provided, however, cause shall include lack of need due to economic considerations.~~

~~(11) (i) There shall be due process for non-institutional providers for all adverse decisions resulting in a change of privileges of a credentialed non-institutional provider. The details of the health plan's due process shall be included in the plan's provider contracts.~~

~~(ii) A health plan is deemed to have met the adequate notice and hearing requirement of this section with respect to a non-institutional provider if the following conditions are met (or are waived voluntarily by the non-institutional provider):~~

~~(A) The provider shall be notified of the proposed actions and the reasons for the proposed action.~~

~~(B) The provider shall be given the opportunity to contest the proposed action.~~

~~(C) The health plan has developed an internal appeals process that has reasonable time limits for the resolution of an internal appeal.~~

~~(12) If the plan places a provider or provider group at financial risk for services not provided by the provider or provider group, the plan must require that a provider or group has met all appropriate standards of the department of business regulation.~~

~~(13) A health plan shall not include a most favored rate clause in a provider contract.~~

~~**23-17.13-4. Penalties and enforcement.** —~~ ~~(a) The director of the department of health may, in lieu of the suspension or revocation of a license, levy an administrative penalty in an amount not less than five hundred dollars ($500) nor more than fifty thousand dollars ($50,000), if reasonable notice, in writing, is given of the intent to levy the penalty and the particular health organization has a reasonable time in which to remedy the defect in its operations which gave rise to the penalty citation. The director of health may augment this penalty by an amount equal to the sum that the director calculates to be the damages suffered by enrollees or other members of the public.~~

~~(b) Any person who knowingly and willfully violates this chapter shall be guilty of a misdemeanor and may be punished by a fine not to exceed five hundred dollars ($500) or by imprisonment for a period not exceeding one year, or both.~~

~~(c) (1) If the director of health shall for any reason have cause to believe that any violation of this chapter has occurred or is threatened, the director of health may give notice to the particular health organization and to their representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation;~~

~~(2) Proceedings under this subsection shall be governed by chapter 35 of title 42.~~

~~(d) (1) The director of health may issue an order directing a particular health organization or a representative of that health organization to cease and desist from engaging in any act or practice in violation of the provisions of this chapter;~~

~~(2) Within thirty (30) days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this chapter have occurred. Those hearings shall be conducted pursuant to §§ 42-35-9 through 42-35-13, and judicial review shall be available as provided by §§ 42-35-15 and 42-35-16.~~

~~(e) In the case of any violation of the provisions of this chapter, if the director of health elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (d), the director of health may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the superior court for the county of Providence.~~

~~23-17.13-5. Severability. --~~ ~~If any section, clause, or provision of this chapter shall be held either unconstitutional or ineffective in whole or in part to the extent that it is not unconstitutional or ineffective, it shall be valid and effective and no other section, clause or provision shall on account thereof be termed invalid or ineffective.~~

~~23-17.13-6. Contracts with providers for dental services. --~~ ~~(a) No contract between a dental plan of a health care entity and a dentist for the provision of services to patients may require that a dentist provide services to its subscribers at a fee set by the health care entity unless said services are covered services under the applicable subscriber agreement. "Covered services," as used herein, means services reimbursable under the applicable subscriber agreement, subject to such contractual limitations on subscriber benefits as may apply, including, for example, deductibles, waiting period or frequency limitations.~~

~~(b) For the purposes of this section "dental plan" shall include any policy of insurance which is issued by a health care entity which provides for coverage of dental services not in connection with a medical plan.~~

~~**23-17.13-7. Contracts with providers and optometric services. –**~~ ~~(a) No contract between an eye care provider and a company offering accident and sickness insurance as defined in chapter 18 of title 27; a nonprofit medical service corporation as defined in chapter 20 of title 27; or a health maintenance organization as defined in chapter 41 of title 27; or a vision plan, may require that an eye care provider provide services or materials to its subscribers at a fee set by the insurer or vision plan unless the insurer or vision plan compensates the eye care provider for the provision of such services or materials to the patient. Reimbursement paid by the insurer or vision plan for covered services and materials shall not provide nominal reimbursement in order to claim that services and materials are covered services.~~

~~(b) (1) "Services" means services and materials for which reimbursement from the vision plan is provided for by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual limitations of deductibles, copayments, or coinsurance.~~

~~(2) "Materials" means and includes, but is not limited to, lenses, devices containing lenses, prisms, lens treatments and coatings, contact lenses, orthoptics, vision training, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa.~~

~~(3) "Eye care provider" means an optometrist, optician, or ophthalmologist.~~

SECTION 3. Chapter 23-17.18 of the General Laws entitled "Health Plan Modification Act" is hereby repealed in its entirety.

~~CHAPTER 23-17.18~~

~~Health Plan Modification Act~~

~~**23-17.18-1. Modification of health plans. –**~~ ~~(a) A health plan may materially modify the terms of a participating agreement it maintains with a physician only if the plan disseminates in writing by mail to the physician the contents of the proposed modification and an explanation, in nontechnical terms, of the modification's impact.~~

~~(b) The health plan shall provide the physician an opportunity to amend or terminate the physician contract with the health plan within sixty (60) days of receipt of the notice of modification. Any termination of a physician contract made pursuant to this section shall be effective fifteen (15) calendar days from the mailing of the notice of termination in writing by mail to the health plan. The termination shall not affect the method of payment or reduce the~~

~~amount of reimbursement to the physician by the health plan for any patient in active treatment for an acute medical condition at the time the patient's physician terminates his, her, or its physician contract with the health plan until the active treatment is concluded or, if earlier, one year after the termination; and, with respect to the patient, during the active treatment period the physician shall be subject to all the terms and conditions of the terminated physician contract, including but not limited to, all reimbursement provisions which limit the patient's liability.~~

~~(c) Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited benefit health insurance policies.~~

SECTION 4. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 18.8

HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT

27-18.8-1. Purpose. -- The legislature declares that:

(1) It is in the best interest of the public that those individuals and health care entities involved with the delivery of plan coverage in our state meet the standards of this chapter to ensure accessibility and quality for the state's patients;

(2) Nothing in this legislation is intended to prohibit a health care entity or contractor from forming limited networks of providers; and

(3) It is a vital state function to establish these standards for the conduct of health plans by a health care entity in Rhode Island.

27-18.8-2. Definitions. -- As used in this chapter:

(1) "Adverse benefit determination" includes a denial, reduction, or termination of, or a failure to provide or make a payment, in whole or in part, for a benefit. A decision by a review agent to authorize a health care service in an alternative setting, a modification of stay, or an alternative treatment shall not constitute an adverse determination if the review agent and provider are in agreement regarding the decision. Adverse benefit determinations include, but are not limited to:

(i) Administrative adverse benefit determination includes any determination that does not require the use of medical judgment, such as a determination of an individual's eligibility to participate in coverage, a determination that a benefit is not a covered benefit, or any rescission of coverage;

(ii) Utilization review adverse benefit determination includes any determination that requires the use of medical judgment to determine whether the service being denied is medically

appropriate and/or necessary, including denial of coverage of a prescription drug because that drug is not on the issuer's formulary and decisions and appeals as defined in chapter 18.9 of title 27.

(2) "Commissioner" means the commissioner of the office of the health insurance commissioner.

(3) "Complaint" means an expression of dissatisfaction by a patient or provider. The appeal of an adverse benefit determination is not considered a complaint.

(4) "Emergency services" has the same meaning as the meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42, as may be amended from time to time, and includes the sudden onset of a medical or mental condition that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily organ or part.

(5) "Health care entity" means a licensed insurance company, hospital, or dental or medical service plan or health maintenance organization, or as described in chapters 18, 19, 20, 21 and 41 of title 27, that operates a health plan.

(6) "Health care services" means and includes, but is not limited to, an admission, diagnostic procedure, therapeutic procedure, treatment, extension of stay, the ordering and/or filling of formulary or non-formulary medications, and any other medical, dental, or behavioral health services, activities, or supplies that are covered by the patient's benefit plan.

(7) "Health plan" means a plan design offered by a health care entity as described in this section that provides for the delivery of care services to persons enrolled in the plan, to include but not be limited to:

(i) Network arrangements with selected providers to furnish health care services;

(ii) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan;

(iii) Cost sharing arrangements;

(iv) Referral process; and/or

(v) Authorization process.

(8) "Professional provider" means an individual provider who provides health care services that is not a facility or institution that contracts separately as a facility or institution.

(9) "Provider" means a physician, hospital, pharmacy, laboratory, dental, medical or behavioral health provider, or other state licensed or other state recognized provider of health care or behavioral health services or supplies, and whose services are recognized pursuant to the

Internal Revenue Code, 26 U.S.C. §213(d), that has entered into an agreement with a health care entity as described in this section to provide these services or supplies to a patient enrolled in a plan.

(10) "Most favored rate clause" means a provision in a provider contract whereby the rates or fees to be paid by a health care entity are fixed, established or adjusted to be equal to or lower than the rates or fees paid to the provider by any other health care entity or third-party payor.

27-18.8-3. Certification of health plans. – (a) Certification process.

(1) Certification.

(i) The commissioner, in consultation with the director of the department of health, shall establish a process for certification of health care entities meeting the requirements of certification in subsection (b) of this section.

(ii) The commissioner shall act upon the health care entity's completed application for certification within ninety (90) days of receipt of such application for certification.

(2) Review and recertification. To ensure compliance, the commissioner shall establish procedures for the periodic review and recertification of a health care entity every five (5) years; provided, however, that the commissioner may review the certification of a health care entity at any time if there exists evidence that a health care entity may be in violation and/or may require periodic compliance attestation.

(3) Cost of certification. The total cost of obtaining and maintaining certification under this title and compliance with the requirements of the applicable rules and regulations are borne by the entities so certified and shall be one hundred and fifty percent (150%) of the total salaries paid to the personnel engaged in those certifications and compliance less any salary reimbursements and shall be paid to the commissioner to and for the use of the office. That assessment shall be in addition to any taxes and fees otherwise payable to the state.

(b) General requirements. The commissioner, in consultation with the director of the department of health, shall establish standards and procedures for the certification of health care entities that conduct business in this state and who have demonstrated the ability to ensure that health care services will be provided in a manner to assure availability and accessibility, adequate personnel and facilities, and continuity of service, and has demonstrated arrangements for ongoing quality assurance programs regarding care processes and outcomes; other standards shall consist of, but are not limited to, the following:

(1) Health care entities must demonstrate that:

(i) They have reasonable access to providers, so that all covered health care services will

be provided. This requirement cannot be waived and must be met in all areas where the health care entity has enrollees;

(ii) Covered health care services shall be available within a time frame that meets standards set by the commissioner;

(iii) A mechanism for enrollees and providers to appeal and grieve decisions and actions of the health care entity.

(2) A comprehensive list of participating providers listed by office location, specialty if applicable, and other information as determined by the commissioner.

(3) Any systemic changes in the health care entity's operations relative to certification information on file shall be submitted to the office for approval by the commissioner within thirty (30) days prior to implementation. For purposes of this chapter, systemic changes are further defined in regulation.

(4) Network requirements. Health care entities must have a provider network that meets the following requirements:

(i) Maintain access to professional, facility and other providers sufficient to provide coverage in a timely manner, of the benefits covered in the health care entity's health insurance plans whereby the health care entity does not impose obstacles that unreasonably affect access to care;

(ii) Establish a process acceptable to the commissioner to monitor the status of network adequacy compliance not less than quarterly;

(iii) If access to in-network providers for any covered benefit is not sufficient to provide necessary care in a timely manner, the health care entity must ensure that the enrollee's access to out of network covered benefits is subject to financial obligations and treatment limitations no more costly or restrictive than the enrollee’s access to an in-network provider for the covered benefit. This shall include situations where a consumer obtains services at an in-network facility and unknowingly and/or is unable to reasonably know in advance that a provider rendering services at or for this facility is a non-participating provider (e.g. anesthesiologist, radiologist and pathologist);

(iv) Establish a process by which the health care entity will ensure that, if a provider withdraws or is terminated from the health care entity's provider network during the plan year, the health care entity will ensure that an enrollee in active treatment for an acute condition with the provider may continue treatment with the provider and be subject to financial obligations and treatment limitations no more costly or restrictive than prior to withdrawal or termination until active treatment is concluded, or, if earlier, one year after the date of withdrawal or termination;

(v) Provide the consumer with up to date information on providers to include:

(A) Location by city, town, county;

(B) Indicate if the provider is accepting new patients; and

(C) Information of potential financial liability due to plan network differentials as well as out-of-network financial liability.

(vi) A process to assure that in cases where participating providers are not accessible and/or available to provide needed care in a timely manner, consumers are not left worse off financially if forced to go to a non-participating provider; and

(vii) A transition of care process when a network has been narrowed and/or providers (facilities and professional) have terminated contracts with the health care entity.

(4) Complaint process. A health care entity shall maintain a complaint resolution process consistent with §27-18.8-2 and acceptable to the office, whereby patients, their physicians, or other health care providers may seek resolution of complaints and other matters of which the review agent has received written notice.

(c) Certification requirements.

(1) A health care entity shall meet all or some of the requirements of certification by providing the required certification information to any state or federal agency in conformance with any other applicable state or federal law, or in conformity with standards adopted by an accrediting organization provided that the commissioner determines that the information is substantially similar to the previously mentioned requirements.

(2) All health care entities shall be required to establish a mechanism, under which providers, including local providers participating in the plan, provide input into the plan's health care policy, including technology, medications and procedures, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures.

(3) All health care entities shall be required to establish a mechanism under which individual subscribers to the plan provide input into the plan's procedures and processes regarding the delivery of health care services.

(4) A health care entity shall not refuse to contract with or compensate for covered services an otherwise eligible provider or non-participating provider solely because that provider has in good faith communicated with one or more of their patients regarding the provisions, terms or requirements of the insurer's products as they relate to the needs of that provider's patients.

(5) The health plan provider contracting and credentialing process shall include the following:

(i) This credentialing process shall begin upon acceptance of an application from a

provider to the plan for inclusion;

(ii) Each application shall be reviewed by the health care entity's credentialing body.

(iii) All health care entities shall develop and maintain credentialing criteria to be utilized in adding providers from the entities' network. Credentialing criteria shall be based on input from providers credentialed in the health care entity and these standards shall be available to applicants. When economic considerations are part of the decisions, the criteria must be available to applicants. Any economic profiling must factor the specialty utilization and practice patterns and general information comparing the applicant to their peers in the same specialty will be made available. Any economic profiling of providers must be adjusted to recognize case mix, severity of illness, age of patients and other features of a provider's practice that may account for higher than or lower than expected costs. Profiles must be made available to those so profiled. The credentialing process shall not impede a patient's ability to access services from a provider in a manner maintaining continuity and quality of care.

(6) A health care entity shall not exclude a provider of covered services from participation in its provider network based solely on:

(i) The provider's degree or license as applicable under state law; or

(ii) The provider of covered services lack of affiliation with, or admitting privileges at a hospital, if that lack of affiliation is due solely to the provider's type of license.

(7) Health care entities shall not discriminate against providers solely because the provider treats a substantial number of patients who require expensive or uncompensated medical care.

(8) The applicant shall be provided with all reasons used if the application is denied.

(9) Health care entities shall not be allowed to include clauses in physician or other provider contracts that allow for the health care entity to terminate the contract "without cause"; provided, however, cause shall include lack of need due to economic considerations.

(10)(i) There shall be due process for non-institutional providers for all adverse decisions resulting in a change of privileges of a credentialed non-institutional provider. The details of the health care entity’s due process shall be included in the health care entity's provider contracts.

(ii) A health care entity is deemed to have met the adequate notice and hearing requirement of this section with respect to a non-institutional provider if the following conditions are met (or are waived voluntarily by the non-institutional provider):

(A) The provider shall be notified of the proposed actions and the reasons for the proposed action;

(B) The provider shall be given the opportunity to contest the proposed action;

(C) The health care entity has developed an internal appeals process that has reasonable time limits for the resolution of an internal appeal.

(11) A health care entity shall not include a most favored rate clause in a provider contract.

(12) A health entity may materially modify the terms of a participating agreement it maintains with a professional provider only if the health care entity disseminates, in writing, by mail to the professional provider, the contents of the proposed modification and an explanation, in nontechnical terms, of the modification's impact.

(13) The health care entity shall provide the professional provider an opportunity to amend or terminate the professional provider contract with the health plan within sixty (60) days of receipt of the notice of modification. Any termination of a professional provider contract made pursuant to this section shall be effective fifteen (15) calendar days from the mailing of the notice of termination, in writing, by mail to the health care entity. The termination shall not affect the method of payment or reduce the amount of reimbursement to the professional provider by the health care entity for any patient in active treatment for an acute medical condition at the time the patient's professional provider terminates their professional provider contract with the health plan until the active treatment is concluded or, if earlier, one year after the termination; and, with respect to the patient, during the active treatment period the professional provider shall be subject to all the terms and conditions of the terminated professional provider contract, including, but not limited to, all reimbursement provisions which limit the patient's liability.

(14) A health care entity must maintain a process, policies and procedures for the modification of formularies and subsequent complaints with the requirements herein and notices to members and providers when formularies change.

27-18.8-4. Contracts with providers for dental services. -- (a) No contract between a dental plan of a health care entity and a dentist for the provision of services to patients may require that a dentist provide services to its subscribers at a fee set by the health care entity unless said services are covered services under the applicable subscriber agreement. "Covered services," as used herein, means services reimbursable under the applicable subscriber agreement, subject to such contractual limitations on subscriber benefits as may apply, including, for example, deductibles, waiting period or frequency limitations.

27-18.8-5. Contracts with providers and optometric services. -- (a) No contract between an eye care provider and a health care entity or vision plan may require that an eye care provider provide services or materials to its subscribers at a fee set by the insurer or vision plan, unless the insurer or vision plan compensates the eye care provider for the provision of such

services or materials to the patient. Reimbursement paid by the insurer or vision plan for covered services and materials shall not provide nominal reimbursement in order to claim that services and materials are covered services.

(b)(1) "Services" means services and materials for which reimbursement from the vision plan is provided for by an enrollee's plan contract, or for which a reimbursement would be available but for the application of the enrollee's contractual limitations of deductibles, copayments, or coinsurance.

(2) "Materials" means and includes, but is not limited to, lenses, devices containing lenses, prisms, lens treatments and coatings, contact lenses, orthoptics, vision training, and prosthetic devices to correct, relieve, or treat defects or abnormal conditions of the human eye or its adnexa.

(3) "Eye care provider" means an optometrist, optician, or ophthalmologist.

27-18.8-6. Penalties and enforcement. -- (a) The commissioner may, in lieu of the suspension or revocation of a license, levy an administrative penalty in an amount not less than five hundred dollars ($500) nor more than fifty thousand dollars ($50,000), provided, that reasonable notice in writing, is given of the intent to levy the penalty, and that the particular health organization has a reasonable time in which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner may augment this penalty by an amount equal to the sum that the commissioner calculates to be the damages suffered by enrollees or other members of the public.

(b) Any person who knowingly and willfully violates this chapter shall be guilty of a misdemeanor and may be punished by a fine not to exceed five hundred dollars ($500) or by imprisonment for a period of not more than one year, or both.

(c)(1) If the commissioner shall for any reason have cause to believe that any violation of this chapter has occurred or is threatened, the commissioner may give notice to the particular health organization and to their representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation;

(2) Proceedings under this subsection shall be governed by chapter 35 of title 42.

(d)(1) The commissioner may issue an order directing a particular health organization or a representative of that health organization to cease and desist from engaging in any act or practice in violation of the provisions of this chapter;

(2) Within thirty (30) days after service of an order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of this chapter have occurred. Those hearings shall be conducted pursuant to §§42-35-9 through 42-35-13, and judicial review shall be available as provided by §§42-35-15 and 42-35-16.

(e) In the case of any violation of the provisions of this chapter, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (d) of this section, the commissioner may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the superior court for the county of Providence.

27-18.8-7. Severability. -- If any section, clause, or provision of this chapter shall be held either unconstitutional or ineffective in whole or in part, to the extent that it is not unconstitutional or ineffective, it shall be valid and effective and no other section, clause or provision shall on account thereof be termed invalid or ineffective.

SECTION 5. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 27-18.9

HEALTH CARE SERVICES-UTILIZATION REVIEW ACT

27-18.9-1. Purpose of chapter. -- The purpose of this chapter is to:

(1) Promote the delivery of quality health care in a cost effective manner;

(2) Foster greater coordination between health care providers, patients, payors and utilization review entities;

(3) Protect patients, businesses, and providers by ensuring that review agents are qualified to perform utilization review activities and to make informed decisions on the appropriateness of medical care; and

(4) Ensure that review agents maintain the confidentiality of medical records in accordance with applicable state and federal laws.

(5) Provide for consultation by the department of health to the office of the health insurance commissioner in furtherance of the purposes of this chapter.

27-18.9-2. Definitions. -- As used in this chapter, the following terms are defined as follows:

(1) "Adverse benefit determination" includes a denial, reduction, or termination of a benefit, or a failure to provide or make a payment (in whole or in part) for a benefit. A decision by a review agent to authorize a health care service in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute an adverse determination if the review

agent and provider are in agreement regarding the decision. Adverse benefit determinations include, but are not limited to:

(i) Administrative adverse benefit determination includes any determination that does not require the use of medical judgment, such as a determination of an individual's eligibility to participate in coverage; a determination that a benefit is not a covered benefit; or any rescission of coverage;

(ii) Utilization review adverse benefit determination includes any determination that requires the use of medical judgment to determine whether the service being denied is medically appropriate and/or necessary, including denial of coverage of a prescription drug because that drug is not on the issuer's formulary and decisions and appeals as defined herein.

(2) "Appeal" means a subsequent review of an adverse determination upon request by a patient or provider to reconsider all or part of the original decision.

(3) "Authorization" means the review agent's utilization review, performed according to this section concluding that the allocation of health care services of a provider, given or proposed to be given to a patient was approved or authorized.

(4) "Certificate" means a certificate of registration granted by the commissioner to a review agent.

(5) "Complaint" means a written expression of dissatisfaction by a patient, or provider. The appeal of an adverse benefit determination is not considered a complaint.

(6) "Concurrent assessment" means an assessment of the medical necessity and/or appropriateness of health care services conducted during a patient's hospital stay or course of treatment. If the medical problem is ongoing, this assessment may include the review of services after they have been rendered and billed.

(7) "Office" means the office of the health insurance commissioner.

(8) "Commissioner" means the health insurance commissioner.

(9) "Emergent health care services" and/or "Emergency health care services" has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42, as may be amended from time to time and includes those resources provided in the event of the sudden onset of a medical, mental health, or substance use or other health care condition manifesting itself by acute symptoms of a severity (e.g. severe pain) where the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part.

(10) "Patient" means an enrollee or participant in all hospital or medical plans seeking

health care services and treatment from a provider.

(11) "Payor" means a health insurer, self-insured plan, nonprofit health service plan, health insurance service organization, preferred provider organization, health maintenance organization or other entity authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state.

(12) "Professional provider" means an individual provider who provides health care services that is not a facility or institution that contracts separately as a facility or institution.

(13) "Prospective assessment" means an assessment of the medical necessity and/or appropriateness of health care services prior to services being rendered.

(14) "Provider" means any health care facility, as defined in §23-17-2 including any mental health and/or substance use treatment facility, physician, or other licensed practitioners identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

(15) "Retrospective assessment" means an assessment of the medical necessity and/or appropriateness of health care services that have been rendered. This shall not include reviews conducted when the review agency has been obtaining ongoing information.

(16) "Review agent" means a person or entity or insurer performing utilization review that is either employed by, affiliated with, under contract with, or acting on behalf of:

(i) A business entity doing business in this state;

(ii) A party that provides or administers health care benefits to citizens of this state, including a health insurer, self-insured plan, nonprofit health service plan, health insurance service organization, preferred provider organization or health maintenance organization authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state; or

(iii) A provider not involved in the care of the patient.

(17) "Same or similar specialty" means a practitioner who has the appropriate training and experience that is the same or similar as the attending provider in addition to experience in treating the same problems to include any potential complications as those under review.

(18) "Urgent health care services" has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42, as may be amended from time to time, and includes those resources necessary to treat a symptomatic medical, mental health, substance use or other health care condition requiring treatment within a twenty-four (24) hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to be emergent health care

services as defined in in this section.

(19) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and/or appropriateness of the allocation of health care services of a provider, given or proposed to be given, to a patient. Utilization review does not include:

(i) The therapeutic interchange of drugs or devices by a pharmacy operating as part of a licensed inpatient health care facility; or

(ii) The assessment by a pharmacist licensed pursuant to the provisions of chapter 19 of title 5, and practicing in a pharmacy operating as part of a licensed inpatient health care facility, in the interpretation, evaluation and implementation of medical orders, including assessments and/or comparisons involving formularies and medical orders.

(20) "Utilization review plan" means a description of the standards governing utilization review activities performed by a private review agent.

(21) "Health care services" means and includes an admission, diagnostic procedure, therapeutic procedure, treatment, extension of stay, the ordering and/or filling of formulary or nonformulary medications, and any other medical, dental, or behavioral health services, activities, or supplies that are covered by the patient's benefit plan.

(22) "Therapeutic interchange" means the interchange or substitution of a drug with a dissimilar chemical structure within the same therapeutic or pharmacological class that can be expected to have similar outcomes and similar adverse reaction profiles when given in equivalent doses, in accordance with protocols approved by the president of the medical staff or medical director and the director of pharmacy.

27-18.9-3. General requirements. -- (a) A review agent shall not conduct utilization review in the state unless the office has granted the review agent a certificate.

(b) Individuals shall not be required to hold separate certification under this chapter when acting as either an employee of, an affiliate of, a contractor for, or otherwise acting on behalf of a certified review agent.

(c) The office shall issue a certificate to an applicant that has met the minimum standards established by this chapter, and regulations promulgated in accordance with it, including the payment of any fees as required, and other applicable regulations of the office.

(d) A certificate issued under this chapter is not transferable, and the transfer of fifty percent (50%) or more of the ownership of a review agent shall be deemed a transfer.

(e) After consultation with the payors and providers of health care, the office shall adopt regulations necessary to implement the provisions of this chapter.

(f) The commissioner is authorized to establish any fees for initial application, renewal

applications, and any other administrative actions deemed necessary by the commissioner to implement this chapter.

(g) The total cost of obtaining and maintain certification under this title and in compliance with the requirements of the applicable rules and regulations shall be borne by the entities so certified and shall be one hundred and fifty percent (150%) of the total salaries paid to the personnel engaged in those certifications and compliance, less any salary reimbursements, and shall be paid to the commissioner to and for the use of the office. That assessment shall be in addition to any taxes and fees otherwise payable to the state.

(h) The application and other fees required under this chapter shall be sufficient to pay for the administrative costs of the certificate program and any other reasonable costs associated with carrying out the provisions of this chapter.

(i) A certificate expires on the third anniversary of its effective date unless the certificate is renewed for a three (3) year term as provided in this chapter.

(j) Any systemic changes in the review agents operations relative to certification information on file shall be submitted to the office for approval by the commissioner within thirty (30) days prior to implementation. For purposes of this chapter, systemic changes are further defined in regulation.

27-18.9-4. Certification and Recertification requirements. -- An application for certification or recertification shall be accompanied by documentation to evidence the following:

(1) The requirement that the review agent provide patients and providers with a summary of its utilization review plan including a summary of the standards, procedures and methods to be used in evaluating proposed or delivered health care services;

(2) The circumstances, if any, under which utilization review may be delegated to any other utilization review program and evidence that the delegated agency is a certified utilization review agency delegated to perform utilization review pursuant to all of the requirements of this chapter;

(3) A complaint resolution process consistent with §27-81-2(5) and acceptable to the office, whereby patients, their physicians, or other health care providers may seek resolution of complaints and other matters of which the review agent has received notice;

(4) The type and qualifications of personnel (employed or under contract) authorized to perform utilization review, including a requirement that only a practitioner with the same license status as the ordering practitioner, or a licensed physician or dentist, is permitted to make a prospective or concurrent adverse determination;

(5) The requirement that a representative of the review agent is reasonably accessible to

patients, patient's family and providers at least five (5) days a week during normal business in Rhode Island and during the hours of the agency's operations when conducting utilization review;

(6) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(7) The policies and procedures regarding the notification and conduct of patient interviews by the review agent;

(8) The requirement that no employee of, or other individual rendering an adverse determination for a review agent may receive any financial incentives based upon the number of denials of certification made by that employee or individual;

(9) The requirement that the utilization review agent shall not impede the provision of health care services for treatment and/or hospitalization or other use of a provider's services or facilities for any patient;

(10) Evidence that the review agent has not entered into a compensation agreement or contract with its employees or agents whereby the compensation of its employees or its agents is based upon a reduction of services or the charges for those services, the reduction of length of stay, or utilization of alternative treatment settings; provided, nothing in this chapter shall prohibit agreements and similar arrangements; and

(11) An adverse benefit determination and internal appeals process consistent with §27-18.9-5 and acceptable to the office, whereby patients, their physicians, or other health care providers may seek prompt reconsideration or appeal of adverse determinations by the review agent.

27-18.9-5. Review agency requirement for adverse determination and internal appeals. -- (a) The adverse benefit determination and appeals process of the review agent shall conform to the following:

(1) Notification of a prospective adverse benefit determination by the review agent shall be mailed or otherwise communicated to the provider of record and to the patient or other appropriate individual as follows:

(i) Within fifteen (15) calendar days of receipt of all the information necessary to complete a review of non-urgent and/or non-emergent services;

(ii) Within seventy-two (72) hours of receipt of all the information necessary to complete a review of urgent and/or emergent services; and

(iii) Prior to the expected date of service.

(2) Notification of a concurrent adverse determination shall be mailed or otherwise communicated to the patient and to the provider of record as follows:

(i) To the provider(s) prior to the end of the current certified period; and

(ii) To the patient within one business day of making the adverse determination.

(3) Notification of a retrospective adverse determination shall be mailed or otherwise communicated to the patient and to the provider of record within thirty (30) calendar days of receipt of a request for payment with all supporting documentation for the covered benefit being reviewed.

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

(5) Any notice of an adverse benefit determination shall include:

(i) The principal reasons for the adverse benefit determination, to include explicit documentation of the criteria not met and/or the clinical rationale utilized by the agency's clinical reviewer in making the adverse determination. The criteria shall be in accordance with the agency criteria noted in §27-18.9-5(d) and shall be made available within the first level appeal timeframe if requested, unless otherwise provided as part of the adverse benefit determination notification process;

(ii) The procedure to initiate an appeal of the adverse benefit determination, including the name and telephone number of the person to contract with regard to an appeal;

(iii) The necessary contact information to complete the two-way direct communication defined in §27-18.9-5(a)(7);

(iv) The necessary notifications shall be provided in a manner that is clear, comprehensive and will not negatively impact the patient; and

(v) The information noted in §27-18.9-5(a)(5) for all verbal notifications followed by written notification to the patient and provider(s).

(6) All initial retrospective adverse benefit determinations of a health care service that had been ordered by a physician, dentist or other practitioner shall be made consistent with regulatory requirements which shall be developed by the office with the input of review agents, providers and other affected parties.

(7) All initial, prospective and concurrent adverse benefit determinations of a health care service that had been ordered by a physician, dentist or other practitioner shall be made, documented, and signed by a licensed practitioner with the same licensure status as the ordering

practitioner or a licensed physician or dentist. This does not prohibit appropriately qualified review agency staff from engaging in discussions with the attending provider, the attending provider's designee or appropriate health care facility and office personnel regarding alternative service and treatment options. Such a discussion shall not constitute an adverse benefit determination; provided, however, that any change to the provider's original order and/or any decision for an alternative level of care must be made and/or appropriately consented to by the attending provider or the provider's designee responsible for treating the patient.

(8) The requirement that, upon written request made by or on behalf of a patient, any adverse benefit determination and/or appeal shall include the written evaluation and findings of the reviewing physician, dentist or other practitioner. The review agent is required to accept a verbal request made by or on behalf of a patient for any information where a provider or patient can demonstrate that a timely response is urgent.

(b) The review agent shall conform to the following for the appeal of an adverse benefit determination:

(1) The review agent shall maintain and make available a written description of the appeal procedure by which either the patient or the provider of record may seek review of determinations not to authorize health care services. The process established by each review agent may include a reasonable period within which an appeal must be filed to be considered and that period shall not be less than one hundred eighty (180) days after receipt of the adverse benefit determination.

(2) The review agent shall notify, in writing, the patient and provider of record of its decision on the appeal as soon as practical, but in no case later than fifteen (15) days, or twenty-one (21) business days if verbal notice is given within fifteen (15) business days after receiving the required documentation on the appeal.

(3) The review agent shall also provide for an expedited appeal process for emergency or life threatening situations. Each review agent shall complete the adjudication of expedited appeals within two (2) business days or seventy-two (72) hours, whichever occurs sooner, of the date the appeal is filed and all information necessary to complete the appeal is received by the review agent.

(4) All first level appeals of determinations not to authorize a health care service that had been ordered by a physician, dentist, or other practitioner shall be made according to the following:

(i) A first level appeal decision of an adverse benefit determination shall not be made until the review agency's professional provider in the same or similar specialty as typically

manages the condition procedure, treatment or requested service under discussion has spoken to, or otherwise provided for, an equivalent two-way direct communication with the patient's attending physician, dentist, other professional provider, other designated or qualified professional provider responsible for treatment of the patient concerning the medical care, with the exception of the following:

(A) When the attending provider is not reasonably available;

(B) When the attending provider chooses not to speak with agency staff;

(C) When the attending provider has negotiated an agreement with the review agent for alternative care; and/or

(D) When the attending provider requests a peer to peer communication prior to the adverse benefit determination, then the review agency shall comply with §27-18.9-5(c)(1) in responding to such a request. Such requests shall be on the case specific basis unless otherwise arranged for in advance by the provider.

(ii) A first level appeal decision shall be made by a review agency professional provider in the same or similar specialty as typically manages the condition, procedure, treatment or requested service under discussion.

(iii) The review agency must document and sign their decision, as referred to in §27-18.9-5(b)(4)(i) by a licensed practitioner with the same licensure status as the ordering practitioner or licensed physician or a licensed dentist.

(5) The review agent shall maintain records of written appeals and their resolution, and shall provide reports as requested by the office.

(c) The review agency must conform to the following requirements when making its adverse benefit determination and appeal decisions:

(1) The review agent must ensure that the licensed practitioner or licensed physician is reasonably available to review the case as required under §27-18.9-5(a)(7) and shall conform to the following:

(i) Each agency peer reviewer shall have access to and review all necessary information as requested by the agency and/or submitted by the provider(s) and/or patients;

(ii) Each agency shall provide accurate peer review contact information to the provider at the time of service, if requested, and/or prior to such service, if requested. This contact information must provide a mechanism for direct communication with the agency's peer reviewer;

(iii) Agency peer reviewers shall respond to the provider's request for a two-way direct communication defined in §27-18.9-5(a)(7)(iv) as follows:

(A) For a prospective review of non-urgent and non-emergent health care services, a response within one business day of the request for a peer discussion;

(B) For concurrent and prospective reviews of urgent and emergent health care services, a response within a reasonable period of time of the request for a peer discussion; and

(C) For retrospective reviews, prior to the first level appeal decision.

(iv) The review agency will have met the requirements of a two-way direct communication, when requested and/or as required prior to the first level of appeal, when it has made two (2) reasonable attempts to contact the attending provider directly.

(v) Repeated violations of this section shall be deemed to be substantial violations pursuant to §27-18.9-7(b) and shall be cause for the imposition of penalties under that section.

(2) No reviewer at any level under this section shall be compensated or paid a bonus or incentive based on making or upholding an adverse determination.

(3) No reviewer under this section who has been involved in prior reviews of the case under appeal or who has participated in the direct care of the patient may participate as the sole reviewer in reviewing a case under appeal; provided, however, that when new information has been made available at the first level of appeal, then the review may be conducted by the same reviewer who made the initial adverse determination.

(4) A review agent is only entitled to review information or data relevant to the utilization review process. A review agent may not disclose or publish individual medical records or any confidential medical information obtained in the performance of utilization review activities. A review agent shall be considered a third-party health insurer for the purposes of §5-37.3-6(b)(6) and shall be required to maintain the security procedures mandated in §5-37.3-4(c).

(5) Notwithstanding any other provision of law, the review agent, the office, and all other parties privy to information which is the subject of this chapter shall comply with all state and federal confidentiality laws, including, but not limited to, chapter 37.3 of title 5 (confidentiality of health care communications and information act) and specifically §5-37.3-4(c), which requires limitation on the distribution of information which is the subject of this chapter on a "need to know" basis, and §40.1-5-26.

(6) The office may, in response to a complaint that is provided in written form to the review agent, review an appeal regarding any adverse determination, and may request information of the review agent, provider or patient regarding the status, outcome or rationale regarding the decision.

(d) The review agents clinical criteria used in making its utilization review decisions shall comply with the following:

(i) The requirement that each review agent shall provide its clinical criteria as required by law;

(ii) Written clinical screening criteria and review procedures are established according to nationally accepted standards and protocols that are periodically evaluated and updated; and

(iii) Establish a process to incorporate and consider local variations to national standards identified in §27-18.9-5(d)(ii) to include input from local participating providers.

(4) The screening criteria and review procedures must comply with the requirements set forth in §27-18.9-5(d) and must meet the satisfaction of the commissioner.

27-18.9-6. External appeal requirements. -- (a) In cases where the internal level of appeal to reverse an adverse benefit determination is unsuccessful, the review agent shall provide for an external appeal by an unrelated and objective appeal agency, selected by the commissioner. The commissioner shall promulgate rules and regulations including, but not limited to, criteria for designation, operation, policy, oversight, and termination of designation as an external appeal agency. The external appeal agency shall not be required to be certified under this chapter for activities conducted pursuant to its designation.

(b) The external appeal shall have the following characteristics:

(1) The external appeal review and decision shall be based on the medical necessity for the health care or service and the appropriateness of service delivery for which authorization has been denied and shall be consistent with local and national standards of care.

(2) Neutral physicians, dentists, or other practitioners in the same or similar general specialty as typically manages the health care service shall be utilized to make the external appeal decisions.

(3) The neutral physician, dentist, or other practitioner may confer either directly with the review agent and provider, or with physicians or dentists appointed to represent them.

(4) Payment for the appeal fee must not exceed twenty-five dollars ($25.00). It must be refunded to the claimant if the adverse benefit determination (or final internal adverse benefit determination) is reversed through external review. The fee must be waived if payment of the fee would impose an undue financial hardship. In addition, the annual limit on the filing fees for any claimant within a single plan year (in the individual market, policy year) must not exceed seventy-five dollars ($75.00). Notwithstanding the aforementioned, this subsection shall not apply to "excepted benefits" as defined in 42 U.S.C. §300gg-91(c).

(5) The decision of the external appeal agency shall be binding; however, any person who is aggrieved by a final decision of the external appeal agency is entitled to judicial review in a court of competent jurisdiction.

27-18.9-7. Denial, suspension, or revocation of certificate. -- (a) The office may deny a certificate upon review of the application if, upon review of the application, it finds that the applicant proposing to conduct utilization review does not meet the standards required by this chapter or by any regulations promulgated pursuant to this chapter.

(b) The office may revoke a certificate and/or impose reasonable monetary penalties not to exceed five thousand dollars ($5,000) per violation in any case in which:

(1) The review agent fails to comply substantially with the requirements of this chapter or with regulations adopted pursuant to this chapter;

(2) The review agent fails to comply with the criteria used by it in its application for a certificate; or

(3) The review agent refuses to permit examination by the commissioner to determine compliance with the requirements of this chapter and regulations promulgated pursuant to the authority granted to the commissioner in this chapter; provided, however, that the examination shall be subject to the confidentiality and "need to know" provisions of §§27-18.9-5(c)(4) and (c)(5). These determinations may involve consideration of any written grievances filed with the office against the review agent by patients or providers.

(c) Any applicant or certificate holder aggrieved by an order or a decision of the office made under this chapter without a hearing may, within thirty (30) days after notice of the order or decision, make a written request to the office for a hearing on the order or decision pursuant to §42-35-15.

(d) The procedure governing hearings authorized by this section shall be in accordance with §§42-35-9 through 42-35-13 as stipulated in §42-35-14(a). A full and complete record shall be kept of all proceedings, and all testimony shall be recorded but need not be transcribed unless the decision is appealed pursuant to §42-35-15. A copy or copies of the transcript may be obtained by any interested party upon payment of the cost of preparing the copy or copies. Witnesses may be subpoenaed by either party.

27-18.9-8. Judicial review. -- Any person who has exhausted all administrative remedies available to them within the office, and who is aggrieved by a final decision of the office under §27-18.9-7, is entitled to judicial review pursuant to §§42-35-15 and 42-35-16.

27-18.9-9. Waiver of requirements. -- (a) The commissioner may waive all or part of the requirements of this chapter if the agent maintains and provides evidence of accreditation by an organization that has been approved by the commissioner and in accordance with regulation.

(b) The office shall waive the requirements of this chapter only when a conflict exists with those activities of a review agent that are conducted pursuant to contracts with the state or

the federal government or those activities under other state or federal jurisdictions.

(c) The office shall waive de minimus activity, in accordance with the regulations adopted by the commissioner.

27-18.9-9.1. Variance of statutory requirements. -- Statutory variances shall be issued for a period not to exceed one year and may be subject to such terms and conditions deemed necessary as determined by the commissioner. Prior to issuing a statutory variance the office shall provide notice and public hearing to ensure necessary patient and health care provider protections in the process.

27-18.9-10. Reporting requirements. -- The office, in consultation with the department of health, shall establish reporting requirements to determine if the utilization review programs are in compliance with the provisions of this chapter and applicable regulations.

27-18.9-11. Lists. -- The commissioner shall periodically provide a list of private review agents issued certificates and the renewal date for those certificates to all licensed health care facilities and any other individual or organization requesting the list.

27-18.9-12. Penalties. -- A person who substantially violates any provision of this chapter or any regulation adopted under this chapter or who submits any false information in an application required by this chapter is guilty of a misdemeanor and on conviction is subject to a penalty not exceeding five thousand dollars ($5,000).

27-18.9-13. Fees. -- The proceeds of any monetary penalties and fines collected pursuant to the provisions of this chapter shall be deposited as general revenues.

27-18.9-14. Severability. -- If any provision of this chapter or the application of any provision to any person or circumstance shall be held invalid, that invalidity shall not affect the provisions or application of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.

SECTION 6. This act shall take effect upon passage and shall be implemented no later than January 1, 2017.

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LC005936
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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY - UTILIZATION REVIEW

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This act would remove utilization review from the department of health and place it within the office of the health insurance commissioner (OHIC). In addition changes would be made to the "Health Care Accessibility and Quality Assurance Act" and the "Health Plan Modification Act" to comply with the Affordable Care Act.

This act would take effect upon passage and would be implemented no later than January 1, 2017.

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