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**ARTICLE 5 AS AMENDED**

**RELATING TO GOVERNMENT REORGANIZATION**

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 Chapter 23-17.12 of the General Laws entitled "Health Care Services - Utilization Review Act" is hereby repealed in its entirety.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

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

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

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

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

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

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

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

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

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

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

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

34           ~~(16) "Retrospective assessment" means an assessment of the medical necessity and/or~~

1 ~~appropriateness of health care services that have been rendered. This shall not include reviews~~  
2 ~~conducted when the review agency has been obtaining ongoing information.~~

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

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

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

11 ~~(iii) A provider.~~

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

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

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

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

26 ~~(ii) Benefit determination; or~~

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

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

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

33 ~~(vi) The assessment by a pharmacist licensed pursuant to the provisions of chapter 19 of~~  
34 ~~title 5 and practicing in a pharmacy operating as part of a licensed inpatient health care facility in~~

1 ~~the interpretation, evaluation and implementation of medical orders, including assessments and/or~~  
2 ~~comparisons involving formularies and medical orders.~~

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

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

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

14 **23-17.12-3. General certificate requirements.**

15 ~~(a) A review agent shall not conduct utilization review in the state unless the department~~  
16 ~~has granted the review agent a certificate.~~

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

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

23 ~~(d) A certificate issued under this chapter is not transferable, and the transfer of fifty percent~~  
24 ~~(50%) or more of the ownership of a review agent shall be deemed a transfer.~~

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

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

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

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

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

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

9 ~~**23-17.12-4. Application process:**~~

10 ~~(a) An applicant requesting certification or recertification shall:~~

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

12 ~~(2) Pay the application fee established by the director through regulation and § 23-17.12-~~  
13 ~~3(f).~~

14 ~~(b) The application shall:~~

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

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

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

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

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

24 ~~(1) A request that the state agency regard specific portions of the standards and criteria or~~  
25 ~~the entire document to constitute "trade secrets" within the meaning of that term in § 38-2-~~  
26 ~~2(4)(i)(B);~~

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

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

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

34 ~~(5) A list of the third party payors and business entities for which the review agent is~~

1 ~~performing utilization review in this state and a brief description of the services it is providing for~~  
2 ~~each client; and~~

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

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

6 **23-17.12-5. General application requirements.**

7 ~~An application for certification or recertification shall be accompanied by documentation~~  
8 ~~to evidence the following:~~

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

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

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

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

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

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

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

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

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

1 ~~facilities for any patient;~~

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

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

10 ~~**23-17.12-6. Denial, suspension, or revocation of certificate.**~~

11 ~~(a) The department may deny a certificate upon review of the application if, upon review~~  
12 ~~of the application, it finds that the applicant proposing to conduct utilization review does not meet~~  
13 ~~the standards required by this chapter or by any regulations promulgated pursuant to this chapter.~~

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

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

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

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

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

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

1 ~~subpoenaed by either party.~~

2 **23-17.12-7. Judicial review.**

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

6 **23-17.12-8. Waiver of requirements.**

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

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

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

24 **23-17.12-8.1. Variance of statutory requirements.**

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

34 ~~(b) On or before January 15th of each year, the department shall issue a report to the general~~



1 assembly summarizing any review agent activity as a result of a waiver granted under the provisions  
2 of this section.

3 ~~**23-17.12-9. Review agency requirement for adverse determination and internal**~~  
4 ~~**appeals.**~~

5 (a) ~~The adverse determination and appeals process of the review agent shall conform to the~~  
6 ~~following:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33           ~~(9) The requirement that, upon written request made by or on behalf of a patient, any~~  
34 ~~adverse determination and/or appeal shall include the written evaluation and findings of the~~

1 ~~reviewing physician, dentist or other practitioner. The review agent is required to accept a verbal~~  
2 ~~request made by or on behalf of a patient for any information where a provider or patient can~~  
3 ~~demonstrate that a timely response is urgent.~~

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

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

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

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

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

23 ~~(5) All second level appeal decisions shall be made, signed, and documented by a licensed~~  
24 ~~practitioner in the same or a similar general specialty as typically manages the medical condition,~~  
25 ~~procedure, or treatment under discussion.~~

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

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

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

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

1           ~~(ii) Each agency shall provide accurate peer review contact information to the provider at~~  
2 ~~the time of service, if requested, and/or prior to such service, if requested. This contact information~~  
3 ~~must provide a mechanism for direct communication with the agency's peer reviewer;~~  
4           ~~(iii) Agency peer reviewers shall respond to the provider's request for a two-way direct~~  
5 ~~communication defined in subdivision 23-17.12-9(a)(7)(iv) as follows:~~  
6           ~~(A) For a prospective review of non-urgent and non-emergent health care services, a~~  
7 ~~response within one business day of the request for a peer discussion;~~  
8           ~~(B) For concurrent and prospective reviews of urgent and emergent health care services, a~~  
9 ~~response within a reasonable period of time of the request for a peer discussion; and~~  
10          ~~(C) For retrospective reviews, prior to the first level appeal decision.~~  
11          ~~(iv) The review agency will have met the requirements of a two-way direct communication,~~  
12 ~~when requested and/or as required prior to the first level of appeal, when it has made two (2)~~  
13 ~~reasonable attempts to contact the attending provider directly.~~  
14          ~~(v) Repeated violations of this section shall be deemed to be substantial violations pursuant~~  
15 ~~to § 23-17.12-14 and shall be cause for the imposition of penalties under that section.~~  
16          ~~(2) No reviewer at any level under this section shall be compensated or paid a bonus or~~  
17 ~~incentive based on making or upholding an adverse determination.~~  
18          ~~(3) No reviewer under this section who has been involved in prior reviews of the case under~~  
19 ~~appeal or who has participated in the direct care of the patient may participate as the sole reviewer~~  
20 ~~in reviewing a case under appeal; provided, however, that when new information has been made~~  
21 ~~available at the first level of appeal, then the review may be conducted by the same reviewer who~~  
22 ~~made the initial adverse determination.~~  
23          ~~(4) A review agent is only entitled to review information or data relevant to the utilization~~  
24 ~~review process. A review agent may not disclose or publish individual medical records or any~~  
25 ~~confidential medical information obtained in the performance of utilization review activities. A~~  
26 ~~review agent shall be considered a third party health insurer for the purposes of § 5-37.3-6(b)(6) of~~  
27 ~~this state and shall be required to maintain the security procedures mandated in § 5-37.3-4(e).~~  
28          ~~(5) Notwithstanding any other provision of law, the review agent, the department, and all~~  
29 ~~other parties privy to information which is the subject of this chapter shall comply with all state~~  
30 ~~and federal confidentiality laws, including, but not limited to, chapter 37.3 of title 5 (Confidentiality~~  
31 ~~of Health Care Communications and Information Act) and specifically § 5-37.3-4(e), which~~  
32 ~~requires limitation on the distribution of information which is the subject of this chapter on a "need~~  
33 ~~to know" basis, and § 40.1-5-26.~~  
34          ~~(6) The department may, in response to a complaint that is provided in written form to the~~

1 ~~review agent, review an appeal regarding any adverse determination, and may request information~~  
2 ~~of the review agent, provider or patient regarding the status, outcome or rationale regarding the~~  
3 ~~decision.~~

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

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

18 ~~(2) Utilization review agents seeking initial certification shall conduct the consultation for~~  
19 ~~all screening and review criteria to be utilized. Utilization review agents who have been certified~~  
20 ~~for one year or longer shall be required to conduct the consultation on a periodic basis for the~~  
21 ~~utilization review agent's highest volume services subject to utilization review during the prior year;~~  
22 ~~services subject to the highest volume of adverse determinations during the prior year; and for any~~  
23 ~~additional services identified by the director.~~

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

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

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

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

9 **23-17.12-10. External appeal requirements:**

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

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

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

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

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

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

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

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

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

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

4           ~~**23-17.12-11. Repealed.**~~

5           ~~**23-17.12-12. Reporting requirements.**~~

6           ~~(a) The department shall establish reporting requirements to determine if the utilization~~  
7 ~~review programs are in compliance with the provisions of this chapter and applicable regulations.~~

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

19           ~~(1) Adverse determination and internal appeals, with particular regard to the time necessary~~  
20 ~~to complete a review of urgent and/or emergent services for patients with behavioral health needs;~~

21           ~~(2) External appeal requirements;~~

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

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

27           ~~**23-17.12-13. Lists.**~~

28           ~~The director shall periodically provide a list of private review agents issued certificates and~~  
29 ~~the renewal date for those certificates to all licensed health care facilities and any other individual~~  
30 ~~or organization requesting the list.~~

31           ~~**23-17.12-14. Penalties.**~~

32           ~~A person who substantially violates any provision of this chapter or any regulation adopted~~  
33 ~~under this chapter or who submits any false information in an application required by this chapter~~  
34 ~~is guilty of a misdemeanor and on conviction is subject to a penalty not exceeding five thousand~~

1 ~~dollars (\$5,000).~~

2 ~~**23-17.12-15. Annual report.**~~

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

8 ~~**23-17.12-16. Fees.**~~

9 ~~The proceeds of any fees, monetary penalties, and fines collected pursuant to the provisions~~  
10 ~~of this chapter shall be deposited as general revenues.~~

11 ~~**23-17.12-17. Severability.**~~

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

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

18 ~~CHAPTER 23-17.13~~

19 ~~Health Care Accessibility and Quality Assurance Act~~

20 ~~**23-17.13-1. Purpose.**~~

21 ~~The legislature declares that:~~

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

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

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

29 ~~**23-17.13-2. Definitions.**~~

30 ~~As used in this chapter:~~

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



1 ~~agreement regarding the decision.~~

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

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

4 ~~(ii) Contracts with an insurance company, a hospital or medical or dental service plan, an~~

5 ~~employer, whether under written or self insured, an employee organization, or any other entity~~

6 ~~providing coverage for health care services to administer a plan; and/or~~

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

8 ~~title.~~

9 ~~(3) "Direct service ratio" means the amount of premium dollars expended by the plan for~~

10 ~~covered services provided to enrollees on a plan's fiscal year basis.~~

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

12 ~~(5) "Emergency services" has the same meaning as the meaning contained in the rules and~~

13 ~~regulations promulgated pursuant to chapter 12.3 of title 42, as may be amended from time to time,~~

14 ~~and includes the sudden onset of a medical or mental condition that the absence of immediate~~

15 ~~medical attention could reasonably be expected to result in placing the patient's health in serious~~

16 ~~jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily~~

17 ~~organ or part.~~

18 ~~(6) "Health care entity" means a licensed insurance company, hospital, or dental or medical~~

19 ~~service plan or health maintenance organization, or a contractor as described in subdivision (2),~~

20 ~~that operates a health plan.~~

21 ~~(7) "Health care services" includes, but is not limited to, medical, mental health, substance~~

22 ~~abuse, and dental services.~~

23 ~~(8) "Health plan" means a plan operated by a health care entity as described in subdivision~~

24 ~~(6) that provides for the delivery of care services to persons enrolled in the plan through:~~

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

26 ~~(ii) Financial incentives for persons enrolled in the plan to use the participating providers~~

27 ~~and procedures provided for by the plan.~~

28 ~~(9) "Provider" means a physician, hospital, pharmacy, laboratory, dentist, or other state~~

29 ~~licensed or other state recognized provider of health care services or supplies, and whose services~~

30 ~~are recognized pursuant to 213(d) of the Internal Revenue Code, 26 U.S.C. § 213(d), that has~~

31 ~~entered into an agreement with a health care entity as described in subdivision (6) or contractor as~~

32 ~~described in subdivision (2) to provide these services or supplies to a patient enrolled in a plan.~~

33 ~~(10) "Provider incentive plan" means any compensation arrangement between a health care~~

34 ~~entity or plan and a provider or provider group that may directly or indirectly have the effect of~~

1 ~~reducing or limiting services provided with respect to an individual enrolled in a plan.~~

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

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

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

9 ~~**23-17.13-3. Certification of health plans.**~~

10 ~~(a) Certification process.~~

11 ~~(1) Certification.~~

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

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

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

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

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

32 ~~(i) Allowable charge;~~

33 ~~(ii) Capitation;~~

34 ~~(iii) Co-payments;~~

- 1           ~~(iv) Co-insurance;~~
- 2           ~~(v) Credentialing;~~
- 3           ~~(vi) Formulary;~~
- 4           ~~(vii) Grace period;~~
- 5           ~~(viii) Indemnity insurance;~~
- 6           ~~(ix) In-patient care;~~
- 7           ~~(x) Maximum lifetime cap;~~
- 8           ~~(xi) Medical necessity;~~
- 9           ~~(xii) Out-of-network;~~
- 10          ~~(xiii) Out-patient;~~
- 11          ~~(xiv) Pre-existing conditions;~~
- 12          ~~(xv) Point of service;~~
- 13          ~~(xvi) Risk sharing;~~
- 14          ~~(xvii) Second opinion;~~
- 15          ~~(xviii) Provider network;~~
- 16          ~~(xix) Urgent care.~~

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

23           ~~(1) Prospective and current enrollees in health plans must be provided information as to~~  
24 ~~the terms and conditions of the plan consistent with the rules and regulations promulgated under~~  
25 ~~chapter 12.3 of title 42 so that they can make informed decisions about accepting and utilizing the~~  
26 ~~health care services of the health plan. This must be standardized so that customers can compare~~  
27 ~~the attributes of the plans, and all information required by this paragraph shall be updated at~~  
28 ~~intervals determined by the director. Of those items required under this section, the director shall~~  
29 ~~also determine which items shall be routinely distributed to prospective and current enrollees as~~  
30 ~~listed in this subsection and which items may be made available upon request. The items to be~~  
31 ~~disclosed are:~~

32           ~~(i) Coverage provisions, benefits, and any restriction or limitations on health care services,~~  
33 ~~including but not limited to, any exclusions as follows: by category of service, and if applicable,~~  
34 ~~by specific service, by technology, procedure, medication, provider or treatment modality;~~

1 ~~diagnosis and condition, the latter three (3) of which shall be listed by name.~~

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

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

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

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

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

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

23 ~~(7) A summary of prior authorization or other review requirements including~~  
24 ~~preauthorization review, concurrent review, post service review, post payment review and any~~  
25 ~~procedure that may lead the patient to be denied coverage for or not be provided a particular service.~~

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

33 ~~(9) Health plans must disclose to prospective and current enrollees the existence of~~  
34 ~~financial arrangements for capitated or other risk sharing arrangements that exist with providers in~~

1 ~~a manner described in paragraphs (i), (ii), and (iii):~~

2 ~~(i) "This health plan utilizes capitated arrangements, with its participating providers, or~~

3 ~~contains other similar risk sharing arrangements;~~

4 ~~(ii) This health plan may include a capitated reimbursement arrangement or other similar~~

5 ~~risk sharing arrangement, and other financial arrangements with your provider;~~

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

7 ~~(10) Written disclosure of criteria for accessing emergency health care services as well as~~

8 ~~a statement of the plan's policies regarding payment for examinations to determine if emergency~~

9 ~~health care services are necessary, the emergency care itself, and the necessary services following~~

10 ~~emergency treatment or stabilization. The health plan must respond to the request of the treating~~

11 ~~provider for post stabilization treatment by approving or denying it as soon as possible.~~

12 ~~(11) Explanation of how health plan limitations impact enrollees, including information on~~

13 ~~enrollee financial responsibility for payment for co insurance, co payment, or other non covered,~~

14 ~~out of pocket, or out of plan services. This shall include information on deductibles and benefits~~

15 ~~limitations including, but not limited to, annual limits and maximum lifetime benefits.~~

16 ~~(12) The terms under which the health plan may be renewed by the plan enrollee, including~~

17 ~~any reservation by the plan of any right to increase premiums.~~

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

19 ~~(14) A schedule of revenues and expenses, including direct service ratios and other~~

20 ~~statistical information which meets the requirements set forth below on a form prescribed by the~~

21 ~~director.~~

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

23 ~~(i) Physician services;~~

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

25 ~~(iii) Other professional services;~~

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

27 ~~office;~~

28 ~~(v) Health education;~~

29 ~~(vi) Substance abuse services and mental health services.~~

30 ~~(16) Plan complaint, adverse decision, and prior authorization statistics. This statistical data~~

31 ~~shall be updated annually:~~

32 ~~(i) The ratio of the number of complaints received to the total number of covered persons,~~

33 ~~reported by category, listed in paragraphs (b)(15)(i) — (vi);~~

34 ~~(ii) The ratio of the number of adverse decisions issued to the number of complaints~~

1 ~~received, reported by category;~~

2 ~~(iii) The ratio of the number of prior authorizations denied to the number of prior~~

3 ~~authorizations requested, reported by category;~~

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

5 ~~filed.~~

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

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

8 ~~be provided. This requirement cannot be waived and must be met in all areas where the health plan~~

9 ~~has enrollees;~~

10 ~~(ii) Urgent health care services, if covered, shall be available within a time frame that meets~~

11 ~~standards set by the director.~~

12 ~~(18) A comprehensive list of participating providers listed by office location, specialty if~~

13 ~~applicable, and other information as determined by the director, updated annually.~~

14 ~~(19) Plans must provide to the director, at intervals determined by the director, enrollee~~

15 ~~satisfaction measures. The director is authorized to specify reasonable requirements for these~~

16 ~~measures consistent with industry standards to assure an acceptable degree of statistical validity~~

17 ~~and comparability of satisfaction measures over time and among plans. The director shall publish~~

18 ~~periodic reports for the public providing information on health plan enrollee satisfaction.~~

19 ~~(c) Issuance of certification.~~

20 ~~(1) Upon receipt of an application for certification, the director shall notify and afford the~~

21 ~~public an opportunity to comment upon the application.~~

22 ~~(2) A health care plan will meet the requirements of certification, subsection (b) by~~

23 ~~providing information required in subsection (b) to any state or federal agency in conformance with~~

24 ~~any other applicable state or federal law, or in conformity with standards adopted by an accrediting~~

25 ~~organization provided that the director determines that the information is substantially similar to~~

26 ~~the previously mentioned requirements and is presented in a format that provides a meaningful~~

27 ~~comparison between health plans.~~

28 ~~(3) All health plans shall be required to establish a mechanism, under which providers,~~

29 ~~including local providers participating in the plan, provide input into the plan's health care policy,~~

30 ~~including technology, medications and procedures, utilization review criteria and procedures,~~

31 ~~quality and credentialing criteria, and medical management procedures.~~

32 ~~(4) All health plans shall be required to establish a mechanism under which local individual~~

33 ~~subscribers to the plan provide input into the plan's procedures and processes regarding the delivery~~

34 ~~of health care services.~~

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

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

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

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

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

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

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

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

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

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

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

33 ~~(11)(i) There shall be due process for non-institutional providers for all adverse decisions~~  
34 ~~resulting in a change of privileges of a credentialed non-institutional provider. The details of the~~

1 ~~health plan's due process shall be included in the plan's provider contracts.~~

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

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

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

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

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

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

14 **23-17.13-4. Penalties and enforcement.**

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

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

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

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

33 ~~(d) (1) The director of health may issue an order directing a particular health organization~~  
34 ~~or a representative of that health organization to cease and desist from engaging in any act or~~



1 ~~practice in violation of the provisions of this chapter;~~

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

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

11 ~~**23-17.13-5. Severability.**~~

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

16 ~~**23-17.13-6. Contracts with providers for dental services.**~~

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

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

26 ~~**23-17.13-7. Contracts with providers and optometric services.**~~

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

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

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

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

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

11 ~~CHAPTER 23-17.18~~

12 ~~Health Plan Modification Act~~

13 ~~23-17.18 1. Modification of health plans.~~

14 ~~(a) A health plan may materially modify the terms of a participating agreement it maintains~~  
15 ~~with a physician only if the plan disseminates in writing by mail to the physician the contents of~~  
16 ~~the proposed modification and an explanation, in nontechnical terms, of the modification's impact.~~

17 ~~(b) The health plan shall provide the physician an opportunity to amend or terminate the~~  
18 ~~physician contract with the health plan within sixty (60) days of receipt of the notice of~~  
19 ~~modification. Any termination of a physician contract made pursuant to this section shall be~~  
20 ~~effective fifteen (15) calendar days from the mailing of the notice of termination in writing by mail~~  
21 ~~to the health plan. The termination shall not affect the method of payment or reduce the amount of~~  
22 ~~reimbursement to the physician by the health plan for any patient in active treatment for an acute~~  
23 ~~medical condition at the time the patient's physician terminates his, her, or its physician contract~~  
24 ~~with the health plan until the active treatment is concluded or, if earlier, one year after the~~  
25 ~~termination; and, with respect to the patient, during the active treatment period the physician shall~~  
26 ~~be subject to all the terms and conditions of the terminated physician contract, including but not~~  
27 ~~limited to, all reimbursement provisions which limit the patient's liability.~~

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

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

33 [CHAPTER 18.8](#)

34 [HEALTH CARE ACCESSIBILITY AND QUALITY ASSURANCE ACT](#)

1           **27-18.8-1. Purpose.**

2           The legislature declares that:

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

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

8           (3) It is a vital state function to establish these standards for the conduct of health care  
9 entities in Rhode Island and for public health well-being; and

10          (4) Nothing in this chapter is intended to prohibit or discourage the health insurance  
11 commissioner from consulting or collaborating with the department of health, or any other state or  
12 federal agency, to the extent the commissioner in his or her discretion determines such consultation  
13 and/or collaboration is necessary and/or appropriate for the administration and enforcement of this  
14 chapter.

15          **27-18.8-2. Definitions.**

16          As used in this chapter:

17          (1) "Adverse benefit determination" means a decision not to authorize a health care service,  
18 including a denial, reduction, or termination of, or a failure to provide or make a payment, in whole  
19 or in part, for a benefit. A decision by a utilization review agent to authorize a health care service  
20 in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute  
21 an adverse determination if the review agent and provider are in agreement regarding the decision.

22          Adverse benefit determinations include:

23           (i) "Administrative adverse benefit determinations," meaning any adverse benefit  
24 determination that does not require the use of medical judgment or clinical criteria such as a  
25 determination of an individual's eligibility to participate in coverage, a determination that a benefit  
26 is not a covered benefit, or any rescission of coverage; and

27           (ii) "Non-administrative adverse benefit determinations," meaning any adverse benefit  
28 determination that requires or involves the use of medical judgement or clinical criteria to  
29 determine whether the service reviewed is medically necessary and/or appropriate. This includes  
30 the denial of treatments determined to be experimental or investigational, and any denial of  
31 coverage of a prescription drug because that drug is not on the health care entity's formulary.

32          (2) "Appeal" or "internal appeal" means a subsequent review of an adverse benefit  
33 determination upon request by a claimant to include the beneficiary or provider to reconsider all or  
34 part of the original adverse benefit determination.

1           (3) "Authorized representative" means an individual acting on behalf of the beneficiary and  
2 shall include: the ordering provider; any individual to whom the beneficiary has given express  
3 written consent to act on his or her behalf; a person authorized by law to provide substituted  
4 consent for the beneficiary; and, when the beneficiary is unable to provide consent, a family  
5 member of the beneficiary.

6           (4) "Beneficiary" means a policy holder subscriber, enrollee, or other individual  
7 participating in a health benefit plan.

8           (5) "Benefit determination" means a decision to approve or deny a request to provide or  
9 make payment for a health care service.

10           (6) "Certificate" means a certificate granted by the commissioner to a health care entity  
11 meeting the requirements of this ~~aet~~ chapter.

12           (7) "Commissioner" means the commissioner of the office of the health insurance  
13 commissioner.

14           (8) "Complaint" means an oral or written expression of dissatisfaction by a beneficiary,  
15 authorized representative, or provider. The appeal of an adverse benefit determination is not  
16 considered a complaint.

17           (9) "Delegate" means a person or entity authorized pursuant to a delegation of authority or  
18 directly or re-delegation of authority, by a health care entity or network plan to perform one or  
19 more of the functions and responsibilities of a health care entity and/or network plan set forth in  
20 this ~~Aet~~ chapter or regulations or guidance promulgated thereunder.

21           (10) "Emergency services" or "emergent services" means those resources provided in the  
22 event of the sudden onset of a medical, behavioral health, or other health condition that the absence  
23 of immediate medical attention could reasonably be expected, by a prudent layperson, to result in  
24 placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions,  
25 or serious dysfunction of any bodily organ or part.

26           (11) "Health benefit plan" or "health plan" means a policy, contract, certificate, or  
27 agreement entered into, offered, or issued by a health care entity to provide, deliver, arrange for,  
28 pay for, or reimburse any of the costs of health care services.

29           (12) "Health care entity" means an insurance company licensed, or required to be licensed,  
30 by the state of Rhode Island or other entity subject to the jurisdiction of the commissioner or the  
31 jurisdiction of the department of business regulation that contracts or offers to contract, or enters  
32 into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health  
33 care services, including, without limitation: a for-profit or nonprofit hospital, medical or dental  
34 service corporation or plan, a health maintenance organization, a health insurance company, or any

1 other entity providing health insurance, accident and sickness insurance, health benefits, or health  
2 care services.

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

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

10 (15) "Network" means the group or groups of participating providers providing health care  
11 services under a network plan.

12 (16) "Network Plan" means a health benefit plan or health plan that either requires a  
13 beneficiary to use, or creates incentives, including financial incentives, for a beneficiary to use the  
14 providers managed, owned, under contract with, or employed by the health care entity.

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

16 (18) "Professional provider" means an individual provider or health care professional  
17 licensed, accredited, or certified to perform specified health care services consistent with state law  
18 and who provides these health care services and is not part of a separate facility or institutional  
19 contract.

20 (19) "Provider" means a physician, hospital, professional provider, pharmacy, laboratory,  
21 dental, medical, or behavioral health provider, or other state-licensed or other state-recognized  
22 provider of health care or behavioral health services or supplies.

23 (20) "Tiered network" means a network that identifies and groups some or all types of  
24 providers into specific groups to which different provider reimbursement, beneficiary cost-sharing,  
25 or provider access requirements, or any combination thereof, apply for the same services.

26 **27-18.8-3. Certification of network plans.**

27 **(a) Certification and Recertification Process.**

28 (1) A health care entity operating a network plan shall not enroll consumers into its plan  
29 unless the office has certified the network plan meeting the requirements herein.

30 (2) The commissioner shall act upon the health care entities' completed applications for  
31 certification of network plans, as determined by the commissioner, within ninety (90) calendar days  
32 of receipt of such applications for certification.

33 (3) To ensure compliance, the commissioner shall establish procedures for the periodic  
34 review and recertification of network plans at least every three (3) years; provided, however, that

1 the commissioner may review the certification of a network plan at any time and/or may require  
2 periodic compliance attestation from a health care entity if, in the commissioner's discretion, he or  
3 she deems it appropriate to do so.

4 (4) Cost of certification. The total cost of obtaining and maintaining a certificate under this  
5 title and in compliance with the requirements of the applicable rules and regulations shall be borne  
6 by the applicant and shall include one hundred fifty percent (150%) of the total salaries paid to the  
7 personnel engaged in certifications and ensuring compliance with the requirements herein and the  
8 applicable rules and regulations. These monies shall be paid to the commissioner to and for the use  
9 of the office and shall be in addition to any taxes and fees otherwise payable to the state.

10 (b) General requirements. The commissioner shall establish standards and procedures for  
11 the certification of network plans that have demonstrated the ability to ensure that health care  
12 services will be provided in a manner to ~~assure~~ ensure availability and accessibility, adequate  
13 personnel and facilities, and continuity of service, and have demonstrated arrangements for ongoing  
14 quality-assurance programs regarding care processes and outcomes. These standards shall consist  
15 of, but are not limited to, the following:

16 (1) As to each network plan, a health care entity must demonstrate it has a mechanism for  
17 beneficiaries and providers to appeal and grieve decisions and actions of the network plan and/or  
18 health care entity, including decisions or actions made by a delegate of the health care entity in  
19 relation to the network plan;

20 (2) As to each network plan, a health care entity must maintain a comprehensive list of  
21 participating providers that meets the requirements herein and provides additional information  
22 relevant to network adequacy;

23 (3) In the event of any substantial systemic changes in the health care entity, network plan,  
24 or any relevant delegate's certification information on file with the office, the health care entity  
25 shall submit notice and explanation of this change for approval by the commissioner at least thirty  
26 (30) calendar days prior to implementation of any such change;

27 (4) As to each network plan, a health care entity shall maintain a complaint resolution  
28 process acceptable to the office, whereby beneficiaries, their authorized representatives, their  
29 physicians, or other health care providers may seek resolution of complaints and other matters of  
30 which the health care entity has received oral or written notice;

31 (5) As to each network plan, a health care entity shall be required to establish a mechanism,  
32 under which providers, including local providers participating in the network plans, provide input  
33 into the plan's health care policy, including: technology, medications and procedures, utilization  
34 review criteria and procedures, quality and credentialing criteria, and medical management

1 procedures;

2 (6) As to each network plan, a health care entity shall be required to establish a mechanism  
3 under which beneficiaries provide input into the health care entity's procedures and processes  
4 regarding the delivery of health care services; and

5 (7) As to each network plan, a health care entity must maintain a process, policies, and  
6 procedures for the modification of formularies to include notices to beneficiaries and providers  
7 when formularies change in accordance with all state and federal laws.

8 (c) Network requirements. For each network plan, health care entities must ensure the  
9 following requirements are met:

10 (1) Maintain access to professional, facility, and other providers sufficient to provide  
11 coverage in a timely manner; of the benefits covered in the network plan and in a manner to assure  
12 that all covered services will be accessible without unreasonable delay;

13 (2) Establish a process acceptable to the commissioner to monitor the status of each  
14 network plan's network adequacy not less frequently than quarterly;

15 (3) Establish and maintain a transition-of-care policy and process when a network has been  
16 narrowed, tiered, and/or providers (facilities and professional) have terminated contracts with the  
17 health care entity for that network plan;

18 (4) Establish a mechanism to provide the beneficiaries and consumers with up-to-date  
19 information on providers, in a form acceptable to the commissioner, to include:

20 (i) Location by city, town, county;

21 (ii) Specialty practice areas;

22 (iii) Affiliations/Admission/Privileges with facilities, including whether those facilities are  
23 in-network facilities; and

24 (iv) Whether the provider is accepting new patients.

25 (d) Contracting and credentialing requirements.

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

31 (2) The health care entity or network plan provider contracting and credentialing process  
32 shall include the following:

33 (i) This credentialing process shall begin upon acceptance of a completed application from  
34 a provider to the health care entity or network plan for inclusion;

1           (ii) Each application shall be reviewed by the health care entity's or network plan's  
2 credentialing body; and

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

12           (3) A health care entity or network plan shall not exclude a professional provider of covered  
13 services from participation in its provider network based solely on:

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

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

18           (4) As to any network plan, health care entities shall not discriminate against providers  
19 solely because the provider treats a substantial number of patients who require expensive or  
20 uncompensated medical care.

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

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

26           (7) There shall be due process for professional providers for all adverse decisions resulting  
27 in a change of privileges or contractual language of a credentialed professional provider.

28           (i) The details of the health care entity or network plan's due process shall be included in  
29 the professional provider contracts.

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

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



1 (B) The professional provider shall be given the opportunity to contest the proposed action;  
2 and

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

5 (8) A health care entity or network plan shall not include a most-favored-rate clause in a  
6 provider contract.

7 (9) A health entity or network plan may materially modify the terms of a participating  
8 agreement it maintains with a professional provider only if it disseminates, in writing, by mail or  
9 by electronic means to the professional provider, the contents of the proposed modification and an  
10 explanation, in non-technical terms, of the modification's impact.

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

24 **27-18.8-4. Contracts with providers for dental services.**

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

31 **27-18.8-5. Contracts with providers ~~and~~ or optometric services.**

32 (a) No contract between an eye care provider and a health care entity or vision plan may  
33 require that an eye care provider provide services or materials to its beneficiaries at a fee set by the  
34 insurer or vision plan, unless the insurer or vision plan compensates the eye care provider for the

1 provision of such services or materials to the beneficiary. Reimbursement paid by the insurer or  
2 vision plan for covered services and materials shall not provide nominal reimbursement in order to  
3 claim that services and materials are covered services.

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

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

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

12 **27-18.8-6. Reporting requirements.**

13 The office shall establish reporting requirements to determine if health care entities and/or  
14 network plans are in compliance with the provisions of this chapter and applicable regulations as  
15 well as in compliance with applicable federal law.

16 **27-18.8-7. Rules and regulations.**

17 The health insurance commissioner may promulgate such rules and regulations as are  
18 necessary and proper to effectuate the purpose and for the efficient administration and enforcement  
19 of this chapter.

20 **27-18.8-8. Denial, suspension, or revocation of certificate.**

21 Adopted pursuant to this chapter:

22 (a) The office may deny a certificate or certification upon review of the application if, upon  
23 review of the application, it finds that the applicant proposing to establish a network plan does not  
24 meet the standards required by this chapter or by any regulations promulgated pursuant to this  
25 chapter.

26 (b) The office may revoke or suspend a certificate or certification and/or impose monetary  
27 penalties not less than one hundred dollars (\$100) and not to exceed fifty thousand dollars (\$50,000)  
28 per violation and/or impose an order requiring a monetary restitution or disgorgement payment in  
29 an amount determined by the commissioner to reasonably reflect the amount of damages caused or  
30 monies improperly obtained in any case in which:

31 (1) The network plan and/or health care entity fails to comply with the requirements of this  
32 chapter or of regulations;

33 (2) The network plan and/or health care entity fails to comply with the criteria used by it  
34 in its application for a certificate or certification; or

1 (3) The network plan and/or health care entity refuses to permit or fails to reasonably  
2 cooperate with an examination by the commissioner to determine compliance with the requirements  
3 of this chapter and regulations promulgated pursuant to the authority granted to the commissioner  
4 in this chapter. These determinations may involve consideration of any written grievances filed  
5 with the office against the network plan or health care entity by patients or providers.

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

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

16 **27-18.8-9. Penalties and enforcement.**

17 For the purposes of this chapter, in addition to the provisions of §27-18.8-8, a health care  
18 entity or any person or entity conducting any activities requiring certification under this chapter  
19 shall be subject to the penalty and enforcement provisions of ~~title 27~~ **this title** and chapters 14 and  
20 14.5 of title 42 and the regulations promulgated thereunder in the same manner as a licensee or any  
21 person or entity conducting any activities requiring licensure or certification under ~~title 27~~ **this title**.

22 **27-18.8-10. Severability.**

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

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

29 CHAPTER 18.9

30 BENEFIT DETERMINATION AND UTILIZATION REVIEW ACT

31 **27-18.9-1. Purpose of chapter.**

32 (a) The purpose of this chapter is to:

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

34 (2) Foster greater coordination between health care providers, patients, health care entities,

1 health benefit plans and utilization-review entities to ensure public health well-being:

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

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

7 (5) Interface and maintain compliance with federal benefit determination and adverse  
8 benefit determination requirements.

9 (b) Nothing in this chapter is intended to prohibit or discourage the health insurance  
10 commissioner from consulting or collaborating with the department of health, or any other state or  
11 federal agency, to the extent the commissioner in his or her discretion determines such consultation  
12 and/or collaboration is necessary and/or appropriate for the administration and enforcement of this  
13 chapter.

14 **27-18.9-2. Definitions.**

15 As used in this chapter, the following terms are defined as follows:

16 (1) "Adverse benefit determination" means a decision not to authorize a health care service,  
17 including a denial, reduction, or termination of, or a failure to provide or make a payment, in whole  
18 or in part, for a benefit. A decision by a utilization-review agent to authorize a health care service  
19 in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute  
20 an adverse determination if the review agent and provider are in agreement regarding the decision.

21 Adverse benefit determinations include:

22 (i) "Administrative adverse benefit determinations," meaning any adverse benefit  
23 determination that does not require the use of medical judgment or clinical criteria such as a  
24 determination of an individual's eligibility to participate in coverage, a determination that a benefit  
25 is not a covered benefit, or any rescission of coverage; and

26 (ii) "Non-administrative adverse benefit determinations," meaning any adverse benefit  
27 determination that requires or involves the use of medical judgement or clinical criteria to  
28 determine whether the service being reviewed is medically necessary and/or appropriate. This  
29 includes the denial of treatments determined to be experimental or investigational, and any denial  
30 of coverage of a prescription drug because that drug is not on the health care entity's formulary.

31 (2) "Appeal" or "internal appeal" means a subsequent review of an adverse benefit  
32 determination upon request by a claimant to include the beneficiary or provider to reconsider all or  
33 part of the original adverse benefit determination.

34 (3) "Authorization" means a review by a review agent, performed according to this ~~aet~~

1 chapter, concluding that the allocation of health care services ordered by a provider, given or  
2 proposed to be given to a beneficiary, was approved or authorized.

3 (4) "Authorized representative" means an individual acting on behalf of the beneficiary and  
4 shall include: the ordering provider; any individual to whom the beneficiary has given express  
5 written consent to act on his or her behalf; a person authorized by law to provide substituted  
6 consent for the beneficiary; and, when the beneficiary is unable to provide consent, a family  
7 member of the beneficiary.

8 (5) "Beneficiary" means a policy-holder subscriber, enrollee, or other individual  
9 participating in a health benefit plan.

10 (6) "Benefit determination" means a decision to approve or deny a request to provide or  
11 make payment for a health care service or treatment.

12 (7) "Certificate" means a certificate granted by the commissioner to a review agent meeting  
13 the requirements of this ~~aet~~ chapter.

14 (8) "Claim" means a request for plan benefit(s) made by a claimant in accordance with the  
15 health care entity's reasonable procedures for filing benefit claims. This shall include pre-service,  
16 concurrent, and post-service claims.

17 (9) "Claimant" means a health care entity participant, beneficiary, and/or authorized  
18 representative who makes a request for plan benefit(s).

19 (10) "Commissioner" means the health insurance commissioner.

20 (11) "Complaint" means an oral or written expression of dissatisfaction by a beneficiary,  
21 authorized representative, or a provider. The appeal of an adverse benefit determination is not  
22 considered a complaint.

23 (12) "Concurrent assessment" means an assessment of health care services conducted  
24 during a beneficiary's hospital stay, course of treatment or services over a period of time, or for the  
25 number of treatments. If the medical problem is ongoing, this assessment may include the review  
26 of services after they have been rendered and billed.

27 (13) "Concurrent claim" means a request for a plan benefit(s) by a claimant that is for an  
28 ongoing course of treatment or services over a period of time or for the number of treatments.

29 (14) "Delegate" means a person or entity authorized pursuant to a delegation of authority  
30 or re-delegation of authority, by a health care entity or network plan to perform one or more of the  
31 functions and responsibilities of a health care entity and/or network plan set forth in this ~~Aaet~~  
32 chapter or regulations or guidance promulgated thereunder.

33 (15) "Emergency services" or "emergent services" means those resources provided in the  
34 event of the sudden onset of a medical, behavioral health, or other health condition that the absence

1 of immediate medical attention could reasonably be expected, by a prudent layperson, to result in  
2 placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions,  
3 or serious dysfunction of any bodily organ or part.

4 (16) "External review" means a review of a non-administrative adverse benefit  
5 determination (including final internal adverse benefit determination) conducted pursuant to an  
6 applicable external review process performed by an Independent Review Organization.

7 ~~(17)~~(18) "Final internal adverse benefit determination" means an adverse benefit  
8 determination that has been upheld by a plan or issuer at the completion of the internal appeals  
9 process or when the internal appeals process has been deemed exhausted as defined in §27-18.9-  
10 7(b)(1) of this act.

11 ~~(18)~~(17) "External review decision" means a determination by an independent review  
12 organization at the conclusion of the external review.

13 (19) "Health benefit plan" or "health plan" means a policy, contract, certificate, or  
14 agreement entered into, offered, or issued by a health care entity to provide, deliver, arrange for,  
15 pay for, or reimburse any of the costs of health care services.

16 (20) "Health care entity" means an insurance company licensed, or required to be licensed,  
17 by the state of Rhode Island or other entity subject to the jurisdiction of the commissioner or the  
18 jurisdiction of the department of business regulation pursuant to chapter 62 of title 42, that contracts  
19 or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or  
20 reimburse any of the costs of health care services, including, without limitation: a for-profit or  
21 nonprofit hospital, medical or dental service corporation or plan, a health maintenance organization,  
22 a health insurance company, or any other entity providing a plan of health insurance, accident and  
23 sickness insurance, health benefits, or health care services.

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

28 (22) "Independent review organization" or "IRO" means an entity that conducts  
29 independent external reviews of adverse benefit determinations or final internal adverse benefit  
30 determinations.

31 (23) "Network" means the group or groups of participating providers providing health care  
32 services under a network plan.

33 (24) "Network plan" means a health benefit plan or health plan that either requires a  
34 beneficiary to use, or creates incentives, including financial incentives, for a beneficiary to use the

1 providers managed, owned, under contract with, or employed by the health care entity.

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

3 ~~(26)~~(27) "Professional provider" means an individual provider or health care professional

4 licensed, accredited, or certified to perform specified health care services consistent with state law

5 and who provides health care services and is not part of a separate facility or institutional contract.

6 ~~(27)~~(28) "Prospective assessment" and/or "pre-service assessment" mean an assessment of

7 health care services prior to services being rendered.

8 ~~(28)~~(26) "Pre-service claim" means the request for a plan benefit(s) by a claimant prior to

9 a services being rendered and is not considered a concurrent claim.

10 (29) "Provider" means a physician, hospital, professional provider, pharmacy, laboratory,

11 dental, medical, or behavioral health provider or other state-licensed or other state-recognized

12 provider of health care or behavioral health services or supplies.

13 (30) "Retrospective assessment" and/or "post-service assessment" means an assessment of

14 health care services that have been rendered. This shall not include reviews conducted when the

15 review agency has been obtaining ongoing information.

16 (31) "Retrospective claim" or "post-service claim" means any claim for a health plan

17 benefit that is not a pre-service or concurrent claim.

18 (32) "Review agent" means a person or health care entity performing benefit determination

19 reviews that is either employed by, affiliated with, under contract with, or acting on behalf of a

20 health care entity.

21 (33) "Same or similar specialty" means a practitioner who has the appropriate training and

22 experience that is the same or similar as the attending provider in addition to experience in treating

23 the same problems to include any potential complications as those under review.

24 (34) "Therapeutic interchange" means the interchange or substitution of a drug with a

25 dissimilar chemical structure within the same therapeutic or pharmacological class that can be

26 expected to have similar outcomes and similar adverse reaction profiles when given in equivalent

27 doses, in accordance with protocols approved by the president of the medical staff or medical

28 director and the director of pharmacy.

29 (35) "Tiered network" means a network that identifies and groups some or all types of

30 providers into specific groups to which different provider reimbursement, beneficiary cost-sharing,

31 or provider access requirements, or any combination thereof, apply for the same services.

32 (36) "Urgent health care services" includes those resources necessary to treat a

33 symptomatic medical, mental health, substance use, or other health care condition that a prudent

34 layperson, acting reasonably, would believe necessitates treatment within a twenty-four (24) hour

1 period of the onset of such a condition in order that the patient's health status not decline as a  
2 consequence. This does not include those conditions considered to be emergent health care services  
3 as defined in in this section.

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

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

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

13 (38) "Utilization review plan" means a description of the standards governing utilization  
14 review activities performed by a review agent.

15 **27-18.9-3. Certification and recertification of review agents.**

16 (a) A review agent shall not conduct benefit determination reviews in the state unless the  
17 office has granted the review agent a certificate.

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

21 (c) The commissioner shall establish a process for the certification of review agents  
22 meeting the requirements of certification.

23 (d) The commissioner shall establish procedures for the periodic review and recertification  
24 of review agents at least every three (3) years.

25 (e) A certificate issued under this chapter is not transferable, and the transfer of fifty percent  
26 (50%) or more of the ownership of a review agent shall be deemed a transfer.

27 (f) The office shall issue a review agent certificate to an applicant **who or** that has met the  
28 minimum standards defined in this chapter, and regulations promulgated in accordance with it,  
29 including the payment of any fees as required, and other applicable regulations of the office.

30 (g) In the event of any systemic changes in the review agent certification information on  
31 file with the office, the review agent shall submit notice and explanation of this change for approval  
32 by the commissioner at least thirty (30) calendar days prior to implementation of any such change.

33 (h) The total cost of obtaining and maintaining a review agent certification under this title  
34 and in compliance with the requirements of the applicable rules and regulations shall be borne by



1 the applicant and shall include one hundred fifty percent (150%) of the total salaries paid to the  
2 personnel engaged in certifications and ensuring compliance with the requirements herein and  
3 applicable rules and regulations. These monies shall be paid to the commissioner to and for the use  
4 of the office and shall be in addition to any taxes and fees otherwise payable to the state.

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

11 (j) The office may, in response to a complaint or inquiry, review a benefit determination or  
12 appeal and may request information of the review agent, provider, or beneficiary regarding the  
13 status, outcome, or rationale regarding any decision. The review agent shall promptly respond to  
14 any such requests by the office.

15 (k) The office shall adopt regulations necessary to implement the provisions of this chapter.

16 **27-18.9-4. Application requirements.**

17 An application for review agent certification or recertification shall include, but is not  
18 limited to, documentation to evidence the following:

19 (a) Administrative and Non-Administrative Benefit Determinations:

20 (1) That the health care entity or its review agent provide beneficiaries and providers with  
21 a summary of its benefit determination review programs and adverse benefit determination criteria  
22 in a manner acceptable to the commissioner that includes a summary of the standards, procedures,  
23 and methods to be used in evaluating proposed, concurrent, or delivered health care services;

24 (2) The circumstances, if any, under which review agent may be delegated to and evidence  
25 that the delegated review agent is a certified review agent pursuant to the requirements of this ~~act~~  
26 chapter;

27 (3) A complaint resolution process acceptable to the commissioner, whereby beneficiaries  
28 or other health care providers may seek resolution of complaints and other matters of which the  
29 review agent has received notice;

30 (4) Policies and procedures to ensure that all applicable state and federal laws to protect  
31 the confidentiality of individual medical records are followed;

32 (5) Requirements that no employee of, or other individual rendering an adverse benefit  
33 determination or appeal decision may receive any financial or other incentives based upon the  
34 number of denials of certification made by that employee or individual;

1 (6) Evidence that the review agent has not entered into a compensation agreement or  
2 contract with its employees or agents whereby the compensation of its employees or its agents is  
3 based, directly or indirectly, upon a reduction of services or the charges for those services, the  
4 reduction of length of stay, or use of alternative treatment settings;

5 (7) An adverse benefit determination and internal appeals process consistent with chapter  
6 18.9 of title 27 and acceptable to the office, whereby beneficiaries, their physicians, or other health  
7 care service providers may seek prompt reconsideration or appeal of adverse benefit determinations  
8 by the review agent according to all state and federal requirements; and

9 (8) That the health care entity or its review agent has a mechanism to provide the  
10 beneficiary or claimant with a description of its claims procedures and any procedures for obtaining  
11 approvals as a prerequisite for obtaining a benefit or for obtaining coverage for such benefit. This  
12 description should, at a minimum, be placed in the summary of benefits document and available on  
13 the review agent's or the relevant health care entity's website and upon request from the claimant,  
14 his/her authorized representative and ordering providers.

15 (b) Non-administrative benefit determinations general requirements:

16 (1) Type and qualifications of personnel (employed or under contract) authorized to  
17 perform utilization review, including a requirement that only a provider with the same license status  
18 as the ordering professional provider or a licensed physician or dentist, is permitted to make a  
19 prospective or concurrent utilization review adverse benefit determination;

20 (2) Requirement that a representative of the utilization review agent is reasonably  
21 accessible to beneficiaries and providers at least five (5) days a week during normal business hours  
22 in Rhode Island and during the hours of the agency's operations when conducting utilization review;

23 (3) Policies and procedures regarding the notification and conduct of patient interviews by  
24 the utilization review agent to include a process and assurances that such interviews do not disrupt  
25 care; and

26 (4) Requirement that the utilization review agent shall not impede the provision of health  
27 care services for treatment and/or hospitalization or other use of a provider's services or facilities  
28 for any beneficiary.

29 **27-18.9-5. Administrative and non-administrative benefit determination procedural**  
30 **requirements.**

31 (a) Procedural failure by claimant.

32 (1) In the event of the failure of claimant or an authorized representative to follow the  
33 health care entities claims procedures for a pre-service claim the health care entity or its review  
34 agent must:

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

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

9 (2) Claimant must have stated name, specific medical condition or symptom and specific  
10 treatment, service, or product for which approval is requested and submitted to proper claim  
11 processing unit.

12 (b) Utilization review agent procedural requirements:

13 (1) All initial, prospective, and concurrent non-administrative, adverse benefit  
14 determinations of a health care service that had been ordered by a physician, dentist, or other  
15 practitioner shall be made, documented, and signed by a licensed practitioner with the same  
16 licensure status as the ordering provider;

17 (2) Utilization review agents are not prohibited from allowing appropriately qualified  
18 review agency staff ~~from engaging to engage~~ in discussions with the attending provider, the  
19 attending provider's designee or appropriate health care facility and office personnel regarding  
20 alternative service and/or treatment options. Such a discussion shall not constitute an adverse  
21 benefit determination; provided, however, that any change to the attending provider's original order  
22 and/or any decision for an alternative level of care must be made and/or appropriately consented to  
23 by the attending provider or the provider's designee responsible for treating the beneficiary and  
24 must be documented by the review agent; and

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

30 **27-18.9-6. Non-administrative benefit determination notifications.**

31 (a) Benefit determination notification timelines. A health care entity and/or its review agent  
32 shall comply with the following:

33 (1) For urgent or emergent health care services, benefit determinations (adverse or non-  
34 adverse) shall be made as soon as possible taking into account exigencies but not later than 72 hours

1 after receipt of the claim.

2 (2) For concurrent claims (adverse or non-adverse), no later than twenty-four (24) hours  
3 after receipt of the claim and prior to the expiration of the period of time or number of treatments.  
4 The claim must have been made to the health care entity or review agent at least twenty-four (24)  
5 hours prior to the expiration of the period of time or number of treatments.

6 (3) For pre-service claims (adverse or non-adverse), within a reasonable period of time  
7 appropriate to the medical circumstances, but not later than fifteen (15) calendar days after the  
8 receipt of the claim. This may be extended up to fifteen (15) additional calendar days if required  
9 by special circumstances and claimant is noticed within the first fifteen (15) calendar-day period.

10 (4) For post-service claims adverse benefit determination no later than thirty (30) calendar  
11 days after the receipt of the claim. This may be extended for fifteen (15) calendar days if  
12 substantiated and claimant is noticed within the first thirty (30) calendar day period.

13 (5) Provision in the event of insufficient information from a claimant.

14 (i) For urgent or emergent care, the health care entity or review agent must notify claimant  
15 as soon as possible, depending on exigencies, but no later than twenty-four (24) hours after receipt  
16 of claim giving specifics as to what information is needed. The health care entity or review agent  
17 must allow claimant at least forty-eight (48) hours to send additional information. The health care  
18 entity or review agent must provide benefit determination as soon as possible and no later than  
19 forty-eight (48) hours after receipt of necessary additional information or end of period afforded to  
20 the claimant to provide additional information, whichever is earlier.

21 (ii) For pre-service and post-service claims, the notice by the health care entity or review  
22 agent must include what specific information is needed. The claimant has forty-five (45) calendar  
23 days from receipt of notice to provide information.

24 (iii) Timelines for decisions, in the event of insufficient information, are paused from the  
25 date on which notice is sent to the claimant and restarted when the claimant responds to the request  
26 for information.

27 (b) Adverse benefit determination notifications form and content requirements. Health care  
28 entities and review agents shall comply with form and content notification requirements, to include  
29 the following:

30 (1) Notices may be written or electronic with reasonable assurance of receipt by claimant  
31 unless urgent or emergent. When urgent or emergent, oral notification is acceptable, absent a  
32 specific request by claimant for written or electronic notice ~~written~~, followed by written or  
33 electronic notification within three (3) calendar days.

34 (2) Notification content shall:

- 1 (i) Be culturally and linguistically appropriate;
- 2 (ii) Provide details of a claim that is being denied to include date of service, provider,  
3 amount of claim, a statement describing the availability, upon request, of the diagnosis code and  
4 its corresponding meaning, and the treatment code and its corresponding meaning as applicable.;
- 5 (iii) Give specific reason or reasons for the adverse benefit determination;
- 6 (iv) Include the reference(s) to specific health benefit plan or review agent provisions,  
7 guideline, protocol, or criterion on which the adverse benefit determination is based;
- 8 (v) If the decision is based on medical necessity, clinical criteria or experimental treatment  
9 or similar exclusion or limit, then notice must include the scientific or clinical judgment for the  
10 adverse determination;
- 11 (vi) Provide information for the beneficiary as to how to obtain copies of any and all  
12 information relevant to **the** denied claim free of charge;
- 13 (vii) Describe the internal and external appeal processes, as applicable, to include all  
14 relevant review agency contacts and OHIC's consumer assistance program information;
- 15 (viii) Clearly state timeline that the claimant has at least one hundred eighty (180) calendar  
16 days following the receipt of notification of an adverse benefit determination to file an appeal; and
- 17 (ix) Be written in a manner to convey clinical rationale in ~~lay person~~ **layperson** terms when  
18 appropriate based on clinical condition and age and in keeping with federal and state laws and  
19 regulations.

20 **27-18.9-7. Internal appeal procedural requirements.**

- 21 (a) Administrative and non-administrative appeals. The review agent shall conform to the  
22 following for the internal appeal of administrative or non-administrative, adverse benefit  
23 determinations:
- 24 (1) The review agent shall maintain and make available a written description of its appeal  
25 procedures by which either the beneficiary or the provider of record may seek review of  
26 determinations not to authorize health care services.
- 27 (2) The process established by each review agent may include a reasonable period within  
28 which an appeal must be filed to be considered and that period shall not be less than one hundred  
29 eighty (180) calendar days after receipt of the adverse benefit determination notice.
- 30 (3) During the appeal, a review agent may utilize a reconsideration process in assessing an  
31 adverse benefit determination. If utilized, the review agent shall develop a reasonable  
32 reconsideration and appeal process, in accordance with this section. For non-administrative,  
33 adverse benefit determinations, the period for the reconsideration may not exceed fifteen (15) days  
34 from the date the request for reconsideration or appeal is received. The review agent shall notify

1 the beneficiary and/or provider of the reconsideration determination with the form and content  
2 described in §27-18.9-6(b), as appropriate. Following the decision on reconsideration, the  
3 beneficiary and/or provider shall have a period of forty-five (45) calendar days during which the  
4 beneficiary and/or provider may request an appeal of the reconsideration decision and/or submit  
5 additional information.

6 (4) Prior to a final internal appeal decision, the review agent must allow the claimant to  
7 review the entire adverse determination and appeal file and allow the claimant to present evidence  
8 and/or additional testimony as part of the internal appeal process.

9 (5) A review agent is only entitled to request and review information or data relevant to the  
10 benefit determination and utilization review processes.

11 (6) The review agent shall maintain records of written adverse benefit determinations,  
12 reconsiderations, appeals and their resolution, and shall provide reports as requested by the office.

13 (7)(i) The review agent shall notify, in writing, the beneficiary and/or provider of record of  
14 its decision on the administrative appeal in no case later than thirty (30) calendar days after receipt  
15 of the request for the review of an adverse benefit determination for pre-service claims, and sixty  
16 (60) days for post-service claims, commensurate with §§29 CFR 2560.503-1(i)(2)(ii) and (iii).

17 (ii) The review agent shall notify, in writing, the beneficiary and provider of record of its  
18 decision on the non-administrative appeal as soon as practical considering medical circumstances,  
19 but in no case later than thirty (30) calendar days after receipt of the request for the review of an  
20 adverse benefit determination, inclusive of the period to conduct the reconsideration, if any. The  
21 timeline for decision on appeal is paused from the date on which the determination on  
22 reconsideration is sent to the beneficiary and/or provider and restarted when the beneficiary and/or  
23 provider submits additional information and/or a request for appeal of the reconsideration decision.

24 (8) The review agent shall also provide for an expedited appeal process for urgent and  
25 emergent situations taking into consideration medical exigencies. Notwithstanding any other  
26 provision of this chapter, each review agent shall complete the adjudication of expedited appeals,  
27 including notification of the beneficiary and provider of record of its decision on the appeal, not  
28 later than seventy-two (72) hours after receipt of the claimant's request for the appeal of an adverse  
29 benefit determination.

30 (9) Benefits for an ongoing course of treatment cannot be reduced or terminated without  
31 providing advance notice and an opportunity for advance review. The review agent or health care  
32 entity is required to continue coverage pending the outcome of an appeal.

33 (10) A review agent may not disclose or publish individual medical records or any  
34 confidential information obtained in the performance of benefit determination or utilization review

1 activities. A review agent shall be considered a third-party health insurer for the purposes of §5-  
2 37.3-6(b)(6) and shall be required to maintain the security procedures mandated in §5-37.3-4(c).

3 (b) Non-administrative appeals. In addition to ~~§27-18.9-7~~ subsection (a) of this section,  
4 the utilization review agents shall conform to the following for its internal appeals adverse benefit  
5 determinations:

6 (1) A claimant is deemed to have exhausted the internal claims appeal process when the  
7 utilization review agent or health care entity fails to strictly adhere to all benefit determination and  
8 appeal processes with respect to a claim. In this case the claimant may initiate an external appeal  
9 or remedies under section 502(a) of ~~ERISA~~ the Employee Retirement Income Security Act of  
10 1974, 29 U.S.C. §1132(a) et seq., or other state and federal law, as applicable.

11 (2) No reviewer under this section, who has been involved in prior reviews or in the adverse  
12 benefit determination under appeal or who has participated in the direct care of the beneficiary,  
13 may participate in reviewing the case under appeal.

14 (3) All internal-level appeals of utilization review determinations not to authorize a health  
15 care service that had been ordered by a physician, dentist, or other provider shall be made according  
16 to the following:

17 (i) The reconsideration decision of a non-administrative, adverse benefit determination  
18 shall not be made until the utilization review agent's professional provider with the same licensure  
19 status as typically manages the condition, procedure, treatment, or requested service under  
20 discussion has spoken to, or otherwise provided for, an equivalent two ~~(2)~~-way, direct  
21 communication with the beneficiary's attending physician, dentist, other professional provider, or  
22 other qualified professional provider responsible for treatment of the beneficiary concerning the  
23 services under review.

24 (ii) A review agent who does not utilize a reconsideration process must comply with the  
25 peer-review obligation described in subsection (b)(3)(i) of this section as part of the appeal process.

26 (iii) When the appeal of any adverse benefit determination, including an appeal of a  
27 reconsideration decision, is based in whole or in part on medical judgment, including  
28 determinations with regard to whether a particular service, treatment, drug, or other item is  
29 experimental, investigational or not medically necessary or appropriate, the reviewer making the  
30 appeal decision must be appropriately trained having the same licensure status as the ordering  
31 provider or be a physician or dentist and be in the same or similar specialty as typically manages  
32 the condition. These qualifications must be provided to the claimant upon request.

33 (iv) The utilization review agency reviewer must document and sign their decisions.

34 (4) The review agent must ensure that an appropriately licensed practitioner or licensed

1 physician is reasonably available to review the case as required under ~~§27-18.9-7-9 (b)~~ **this**  
2 subsection (b) and shall conform to the following:

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

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

8 (iii) Agency peer reviewers shall respond to the provider's request for a two-~~(2)~~ way, direct  
9 communication defined in ~~§27-18.9-7 (b)~~ **this subsection (b)** as follows:

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

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

14 (C) For retrospective reviews, prior to the internal-level appeal decision.

15 (5) The review agency will have met the requirements of a two-way, direct communication,  
16 when requested and/or as required prior to the internal level of appeal, when it has made two (2)  
17 reasonable attempts to contact the attending provider directly. Repeated violations of this section  
18 shall be deemed to be substantial violations pursuant to ~~§27-18.9-9~~ **27-18.9-13** and shall be cause  
19 for the imposition of penalties under that section.

20 (6) For the appeal of an adverse benefit determination decision that a drug is not covered,  
21 the review agent shall complete the internal-appeal determination and notify the claimant of its  
22 determination:

23 (i) No later than seventy-two (72) hours following receipt of the appeal request; or

24 (ii) No later than twenty-four (24) hours following the receipt of the appeal request in cases  
25 where the beneficiary is suffering from a health condition that may seriously jeopardize the  
26 beneficiary's life, health, or ability to regain maximum function or when an beneficiary is  
27 undergoing a current course of treatment using a non-formulary drug.

28 (iii) And if approved on appeal, coverage of the non-formulary drug must be provided for  
29 the duration of the prescription, including refills unless expedited then for the duration of the  
30 exigency.

31 (7) The review agents using clinical criteria and medical judgment in making utilization  
32 review decisions shall comply with the following:

33 (i) The requirement that each review agent shall provide its clinical criteria to OHIC upon  
34 request;



1 (ii) Provide and use written clinical criteria and review procedures established according  
2 to nationally accepted standards, evidence-based medicine and protocols that are periodically  
3 evaluated and updated or other reasonable standards required by the commissioner;

4 (iii) Establish and employ a process to incorporate and consider local variations to national  
5 standards and criteria identified herein including without limitation, a process to incorporate input  
6 from local participating providers; and

7 (iv) Updated description of clinical decision criteria to be available to beneficiaries,  
8 providers, and the office upon request and readily available accessible on the health care entity or  
9 the review agent's website.

10 (8) The review agent shall maintain records of written, adverse benefit determination  
11 reconsiderations and appeals to include their resolution, and shall provide reports and other  
12 information as requested by the office.

13 **27-18.9-8. External appeal procedural requirements.**

14 (a) General requirements.

15 (1) In cases where the non-administrative, adverse benefit determination or the final  
16 internal level of appeal to reverse a non-administrative, adverse benefit determination is  
17 unsuccessful, the health care entity or review agent shall provide for an external appeal by an  
18 independent review organization (IRO) approved by the commissioner and ensure that the  
19 external appeal complies with all applicable laws and regulations.

20 (2) In order to seek an external appeal, claimant must have exhausted the internal claims  
21 and appeal process unless the utilization review agent or health care entity has waived the internal  
22 appeal process by failing to comply with the internal appeal process or the claimant has applied for  
23 expedited external review at the same time as applying for expedited internal review.

24 (3) A claimant shall have at least four (4) months after receipt of a notice of the decision  
25 on a final internal appeal to request an external appeal by an IRO.

26 (4) Health care entities and review agents must use a rotational IRO registry system  
27 specified by the commissioner, and must select an IRO in the rotational manner described in the  
28 IRO registry system.

29 (5) A claimant requesting an external appeal may be charged no more than a twenty-five  
30 dollars (\$25.00) external appeal fee by the review agent. The external appeal fee, if charged, must  
31 be refunded to the claimant if the adverse benefit determination is reversed through external review.  
32 The external appeal fee must be waived if payment of the fee would impose an undue financial  
33 hardship on the beneficiary. In addition, the annual limit on external appeal fees for any beneficiary  
34 within a single plan year (in the individual market, within a policy year) must not exceed seventy-

1 five dollars (\$75.00). Notwithstanding the aforementioned, this subsection shall not apply to  
2 excepted benefits as defined in 42 U.S.C. 300 gg-91(c).

3 (6) IRO and/or the review agent and/or the health care entity may not impose a minimum  
4 dollar amount of a claim for a claim to be eligible for external review by an IRO.

5 (7) The decision of the external appeal by the IRO shall be binding on the health care entity  
6 and/or review agent; however, any person who is aggrieved by a final decision of the external  
7 appeal agency is entitled to judicial review in a court of competent jurisdiction.

8 (8) The health care entity must provide benefits (including making payment on the claim)  
9 pursuant to an external review decision without delay regardless whether the health care entity or  
10 review agent intends to seek judicial review of the IRO decision.

11 (9) The commissioner shall promulgate rules and regulations including, but not limited to,  
12 criteria for designation, operation, policy, oversight, and termination of designation as an IRO. The  
13 IRO shall not be required to be certified under this chapter for activities conducted pursuant to its  
14 designation.

15 (b) The external appeal process shall include, but not be limited to, the following  
16 characteristics:

17 (1) The claimant must be noticed that he/she shall have at least five (5) business days from  
18 receipt of the external appeal notice to submit additional information to the IRO.

19 (2) The IRO must notice the claimant of its external appeal decision to uphold or overturn  
20 the review agency decision:

21 (i) No more than ten (10) calendar days from receipt of all the information necessary to  
22 complete the external review and not greater than forty-five (45) calendar days after the receipt of  
23 the request for external review; and

24 (ii) In the event of an expedited external appeal by the IRO for urgent or emergent care, as  
25 expeditiously as possible and no more than seventy-two (72) hours after the receipt of the request  
26 for the external appeal by the IRO. Notwithstanding provisions in this section to the contrary, this  
27 notice may be made orally but must be followed by a written decision within forty-eight (48) hours  
28 after oral notice is given.

29 (3) For an external appeal of an internal appeal decision that a drug is not covered, the IRO  
30 shall complete the external appeal determination and notify the claimant of its determination:

31 (i) No later than seventy-two (72) hours following receipt of the external appeal request;  
32 or;

33 (ii) No later than twenty-four (24) hours following the receipt of the external appeal request  
34 if the original request was an expedited request; and

1 (iii) If approved on external appeal, coverage of the non-formulary drug must be provided  
2 for the duration of the prescription, including refills, unless expedited then for the duration of the  
3 exigencies.

4 (c) External appeal decision notifications. The health care entity and review agent must  
5 ensure that the IRO adheres to the following relative to decision notifications:

6 (1) May be written or electronic with reasonable assurance of receipt by claimant unless  
7 urgent or emergent. If urgent or emergent, oral notification is acceptable followed by written or  
8 electronic notification within three (3) calendar days;

9 (2) Must be culturally and linguistically appropriate;

10 (3) The details of claim that is being denied to include the date of service, provider name,  
11 amount of claim, diagnostic code, and treatment costs with corresponding meanings;

12 (4) Must include the specific reason or reasons for the external appeal decision;

13 (5) Must include information for claimant as to procedure to obtain copies of any and all  
14 information relevant to the external appeal which copies must be provided to the claimant free of  
15 charge; and;

16 (6) Must not be written in a manner that could reasonably be expected to negatively impact  
17 the beneficiary.

18 **27-18.9-9. Reporting requirements.**

19 The office shall establish reporting requirements to determine if adverse benefit  
20 determination and/or utilization review programs are in compliance with the provisions of this  
21 chapter and applicable regulations as well as in compliance with applicable federal law.

22 **27-18.9-10. Rules and regulations.**

23 The health insurance commissioner may promulgate such rules and regulations as are  
24 necessary and proper to effectuate the purpose and for the efficient administration and enforcement  
25 of this chapter.

26 **27-18.9-11. Waiver of requirements.**

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

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

32 **27-18.9-12. Variance of statutory requirements.**

33 Statutory variances shall be issued for a period not to exceed one year and may be subject  
34 to such terms and conditions deemed necessary as determined by the commissioner. Prior to issuing

1 a statutory variance, the office may provide notice and public hearing to ensure necessary  
2 beneficiary and health care provider protections in the process.

3 **27-18.9-13. Denial, suspension, or revocation of certificate.**

4 Adopted pursuant to this chapter;

5 (a) The office may deny a certificate or certification upon review of the application if, upon  
6 review of the application, it finds that the applicant proposing to conduct utilization review does  
7 not meet the standards required by this chapter or by any regulations promulgated pursuant to this  
8 chapter.

9 (b) The office may revoke or suspend a certificate or certification and/or impose monetary  
10 penalties not less than one hundred dollars (\$100) and not to exceed fifty thousand dollars (\$50,000)  
11 per violation and/or impose an order requiring a monetary restitution or disgorgement payment in  
12 an amount determined by the commissioner to reasonably reflect the amount of damages caused or  
13 monies improperly obtained in any case in which:

14 (1) The health care entity and/or review agent fails to comply with the requirements of this  
15 chapter or of regulations;

16 (2) The review agent/network plan and/or health care entity and/or review agent fails to  
17 comply with the criteria used by it in its application for a certificate or certification; or

18 (3) The health care entity and/or review agent refuses to permit or fails to reasonably  
19 cooperate with an examination by the commissioner to determine compliance with the requirements  
20 of this chapter and regulations promulgated pursuant to the authority granted to the commissioner  
21 in this chapter. These determinations may involve consideration of any written grievances filed  
22 with the office against the health care entity and/or review agent by patients or providers.

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

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

33 **27-18.9-14. Penalties and enforcement.**

34 For the purposes of this chapter, in addition to the provisions of §27-18.9-13, a health care

1 [entity and/or review agent or any person or entity conducting any activities requiring certification](#)  
2 [under this chapter shall be subject to the penalty and enforcement provisions of title 27 and chapters](#)  
3 [14 and 14.5 of title 42 and the regulations promulgated thereunder in the same manner as a licensee](#)  
4 [or any person or entity conducting any activities requiring licensure or certification under title 27.](#)

5 **27-18.9-15. Severability.**

6 [If any provision of this chapter or the application of any provision to any person or](#)  
7 [circumstance shall be held invalid, that invalidity shall not affect the provisions or application of](#)  
8 [this chapter which can be given effect without the invalid provision or application, and to this end](#)  
9 [the provisions of this chapter are declared to be severable.](#)

10 SECTION 6. Section 36-4-34.1 of the General Laws in Chapter 36-4 entitled "Merit  
11 System" is hereby amended to read as follows:

12 **36-4-34.1. Transfer of state employees.**

13 [\(a\) The director of the department of administration \(the "director"\) is hereby authorized](#)  
14 [to transfer any employee within the executive branch who is not covered by a collective bargaining](#)  
15 [unit as provided in chapter 11 of this title. Any employee may be transferred to a comparable](#)  
16 [position upon the approval of the director of the department of administration and the personnel](#)  
17 [administrator. The transfers may be initially authorized for a period up to one year's duration and](#)  
18 [may be further extended with the approval of the personnel administrator \(the "personnel](#)  
19 [administrator"\).](#)

20 [\(b\) Within seven \(7\) days of making a transfer of an employee or further extending the](#)  
21 [duration of a transfer as provided by subsection \(a\), the director making the transfer or the personnel](#)  
22 [administrator extending the transfer shall file a written report with the speaker of the house, the](#)  
23 [senate president, and the chairpersons of the house and senate finance committees, for each](#)  
24 [employee to be transferred. This report shall include:](#)

25 [\(1\) The identity of the employee;](#)

26 [\(2\) The employee's current work position and location, and the proposed new work position](#)  
27 [and location;](#)

28 [\(3\) The reason\(s\) for the employee transfer;](#)

29 [\(4\) The specific task\(s\) to be assigned to and completed by the transferred employee;](#)

30 [\(5\) An explanation of how the task\(s\) to be completed by the transferred employee relates](#)  
31 [to the mission of the transferee department, division or agency; and](#)

32 [\(6\) The anticipated duration of the employee's transfer.](#)

33 SECTION 7. Section 44-1-14 of the General Laws in Chapter 44-1 entitled "State Tax  
34 Officials" is hereby amended as follows:

1           **44-1-14. Disclosure of information to tax officials of federal government or other**  
2 **states, or to other persons.**

3           Notwithstanding any other provision of law:

4           (1) The tax administrator may make available: ~~(i) To~~ the taxing officials of any other states  
5 or of the federal government for tax purposes only, any information that the administrator may  
6 consider proper contained in tax reports or returns or any audit or the report of any investigation  
7 made with respect to them, filed pursuant to the tax laws of this state; provided, that other states or  
8 the federal government grant like privileges to the taxing officials of this state; ~~and/or (ii) To an~~  
9 officer or employee of the office of internal audit of the Rhode Island department of administration,  
10 any information that the administrator may consider proper contained in tax reports or returns or  
11 any audit or the report of any investigation made with respect to them, filed pursuant to the tax laws  
12 of this state, to whom disclosure is necessary for the purposes of fraud detection and prevention in  
13 any state or federal program.

14           (2) The tax administrator shall not permit any federal return or federal return information  
15 to be inspected by, or disclosed to, an individual who is the chief executive officer of the state or  
16 any person other than:

17           (i) To another employee of the tax division for the purpose of, and only to the extent  
18 necessary in, the administration of the state tax laws for which the tax division is responsible;

19           (ii) To another officer or employee of the state to whom the disclosure is necessary in  
20 connection with processing, storage, and transmission of those returns and return information and  
21 solely for purposes of state tax administration;

22           (iii) To another person for the purpose of, but only to the extent necessary in, the  
23 programming, maintenance, repair, testing, and procurement of equipment used in processing or  
24 transmission of those returns and return information; or

25           (iv) To a legal representative of the tax division, personally and directly engaged in, and  
26 solely for use in, preparation for a civil or ~~civil~~ criminal proceeding (or investigation which may  
27 result in a proceeding) before a state administrative body, grand jury, or court in a matter involving  
28 state tax administration, but only if:

29           (A) The taxpayer is or may be a party to the proceeding;

30           (B) The treatment of an item reflected on the return is or may be related to the resolution  
31 of an issue in the proceeding or investigation; or

32           (C) The return or return information relates, or may relate, to a transactional relationship  
33 between a person who is or may be a party to the proceeding and the taxpayer that affects or may  
34 affect the resolution of an issue in a proceeding or investigation.

1 SECTION 8. Section 36-4-16.4 of the General Laws in Chapter 36-4 entitled "Merit  
2 System" is hereby amended to read as follows:

3 **36-4-16.4. Salaries of directors.**

4 (a) In the month of March of each year, the department of administration shall conduct a  
5 public hearing to determine salaries to be paid to directors of all state executive departments for the  
6 following year, at which hearing all persons shall have the opportunity to provide testimony, orally  
7 and in writing. In determining these salaries, the department of administration will take into  
8 consideration the duties and responsibilities of the aforementioned officers, as well as such related  
9 factors as salaries paid executive positions in other states and levels of government, and in  
10 comparable positions anywhere ~~which~~ **that** require similar skills, experience, or training.  
11 Consideration shall also be given to the amounts of salary adjustments made for other state  
12 employees during the period that pay for directors was set last.

13 (b) Each salary determined by the department of administration will be in a flat amount,  
14 exclusive of such other monetary provisions as longevity, educational incentive awards, or other  
15 fringe additives accorded other state employees under provisions of law, and for which directors  
16 are eligible and entitled.

17 (c) In no event will the department of administration lower the salaries of existing directors  
18 during their term of office.

19 (d) Upon determination by the department of administration, the proposed salaries of  
20 directors will be referred to the general assembly by the last day in April of that year to go into  
21 effect thirty (30) days hence, unless rejected by formal action of the house and the senate acting  
22 concurrently within that time.

23 (e) Notwithstanding the provisions of this section, for 2015 only, the time period for the  
24 ~~D~~department of ~~A~~administration to conduct the public hearing shall be extended to July and the  
25 proposed salaries shall be referred to the general assembly by August 30. The salaries may take  
26 effect before next year, but all other provisions of this section shall apply.

27 (f) Notwithstanding the provisions of this section or any law to the contrary, for 2017 only,  
28 the salaries of the director of the department of transportation, the secretary of health and human  
29 services, and the director of administration shall be determined by the governor.

30 SECTION 9. Sections 1 through 5 shall take effect as of January 1, 2018; provided  
31 however, upon passage, the Office of the Health Insurance Commissioner may waive the filing and  
32 other requirements for entities that would not be required to file or become subject to oversight  
33 consistent with the terms of Sections 1 through 5. ~~Sections 6 and 9~~ Section 8 shall take effect upon  
34 passage, and ~~sections 7 and 8~~ sections 6 and 7 shall take effect as of July 1, 2017.