[27 R.I. Gen. Laws § 27-18.8-3.]

§ 27-18.8-3. Certification of network plans: Health Care Accessibility and Quality Assurance Act

(a) Certification and Recertification Process.

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

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

(3) To ensure compliance, the commissioner shall establish procedures for the periodic review and recertification of network plans at least every three (3) years; provided, however, that the commissioner may review the certification of a network plan at any time and/or may require periodic compliance attestation from a health care entity if, in the commissioner's discretion, he or she deems it appropriate to do so.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Location by city, town, county;

(ii) Specialty practice areas;

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

(iv) Whether the provider is accepting new patients.

(d) Contracting and credentialing requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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