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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2002

A N A C T

RELATING TO HEALTH AND SAFETY -- MANAGED CARE LIABILITY

Introduced By: Representative Suzanne M. Henseler

Date Introduced: February 05, 2002

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Title 23 of the General Laws entitled "Health and Safety" is hereby amended by adding thereto the following chapter:

CHAPTER 17.20

MANAGED CARE LIABILITY

23-17.20-1. Definitions. – As used in this chapter:

(1) "Medically necessary and appropriate" means the standard for health care services defined in section 23-17.12-3(10).

(2) "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents.

(3) "Health care entity" means (i) a licensed insurance company; (ii) hospital or medical service plan; (iii) health maintenance organization; or (iv) contractor as defined in section 23-17.13-2. Provided, however, that the term "health care entity" shall not include dental service plans.

(4) "Health plan" means a plan operated by a health care entity that provides for the delivery of health care services to persons enrolled in such plans through:

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

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

(5) "Health care provider" means a physician, hospital, pharmacy, laboratory, or other

state licensed or state recognized provider of health care services or supplies that has entered into an agreement with a health care entity to provide such services or supplies to patients enrolled in a health plan.

(6) "Health care treatment decision" means a determination made when medical services are actually provided by the health care plan and/or a decision which affects the quality of the diagnosis, care or treatment provided to the plan's insured or enrollees.

(7) "Health maintenance organization" means an organization as defined in section 27-41-2.

(8) "Physician" means an individual licensed to practice medicine in this state pursuant to chapter 37 of title 5 or a professional services corporation of physicians authorized to practice pursuant to section 7-5.1-3.

(9) "Ordinary care" means in the case of a health care entity, that degree of care that a health care entity of ordinary prudence would use under the same or similar circumstances. In case of a person who is an employee, agent, or representative of a health care entity, "ordinary care" means that degree of care that a person of ordinary prudence in the same profession, specialty or area of practice as such person would use in the same or similar circumstances.

(10) "Utilization review agent" means a review agent as defined in section 23-17.12-2.

23-17.20-2. Application. – (a) A health care entity has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an enrollee proximately caused by its failure to exercise such ordinary care; provided, however, that no health care entity shall be liable for punitive damages pursuant to this section.

(b) A health care entity is also liable for damages for harm to an insured enrollee proximately caused by the health care treatment decisions made by its:

(1) employees; or

(2) agents; or

(3) representatives who are acting on its behalf and over whom it has the right to exercise influence or control or has actually exercised influence or control which results in the failure to exercise ordinary care.

(c) It shall be a defense to any action asserted against a health care entity pursuant to this chapter that:

(1) neither the health care entity nor any employee, agent or representative for whose conduct such health care entity is liable under subsection (b) controlled, influenced or participated in the health care treatment decision; and

(2) the health care entity did not deny or delay approval or payment or make and adverse

determination as defined in section 23-17.12-2(1), for any treatment prescribed or recommended by a health care provider to the enrollee.

(d) The standards in subsections (a) and (b) shall not create an obligation on the part of the health care entity to provide to an enrollee treatment which is not covered by the applicable health plan.

(e) This chapter shall not create any liability on the part of an employer or an employer group purchasing organization, unless the employer is a health care entity subject to liability pursuant to this chapter.

(f) This chapter shall not create any liability on the part of a pharmacy licensed by the state board of pharmacy that purchases coverage or assumes risk on behalf of its employees.

(g) A health care entity may not remove a health care provider from its plan or refuse to renew the health care provider with its plan or otherwise penalize a health care provider for advocating on behalf of an enrollee for medically necessary and appropriate health care.

(h) A health care entity may not enter into a contract with a health care provider which includes an indemnification or hold harmless clause for the acts, conduct or omissions of the health care entity. Any such indemnification or hold harmless clause, or any other purported waiver, alteration or transfer of the duty prescribed in section 23-17.15-3 is hereby declared void.

(i) The provisions of section 27-41-22, or any other provision in the general laws prohibiting or preventing a health care entity from practicing medicine, shall not be asserted as a defense by such health care entity in an action brought against it pursuant to this chapter or any other law.

(j) In an action against a health care entity, a finding that a physician or other health care provider is an employee, agent or representative of such health care entity shall not be based solely on proof that such person's name appears in a listing of approved physicians or health care providers made available to insurers or enrollees under a health care plan.

(k) This section shall not apply to workers' compensation insurance coverage.

23-17.20-3. Limitation on cause of action. – (a) An enrollee may not maintain a cause of action pursuant to this chapter against a health care entity unless the affected enrollee, or the enrollee's representative, has:

(1) delivered or mailed written notice of the action to the health care entity at least thirty (30) days before instituting said action;

(2) exhausted the appeals process available pursuant to chapter 17.12 of title 23.

(b) If the enrollee has not complied with subsection (a), the court shall not dismiss an action brought pursuant to this chapter but may, in its discretion, order the parties to submit to an

external appeal, mediation or other alternative dispute resolution and may abate the action for a period of not to exceed thirty (30) days for such purposes. Such order of the court shall be the sole remedy available to a party complaining of an enrollee's failure to comply with subsection (a).

(c) If the enrollee, or the enrollee's representative, seeks to exhaust an appeal process available pursuant to chapter 17.12 of title 23, and provides notice pursuant to subsection (a) of this subsection, before the applicable statute of limitations has expired, the limitation period is tolled until the later of:

(1) the thirtieth (30th) day after the date the enrollee, or the enrollee's representative , has exhausted the appeals process; or

(2) the fortieth (40th) day after the date that notice was provided.

(d) If exhaustion of the appeals process would place the enrollee's health in serious jeopardy, the enrollee shall not be prohibited from pursuing other remedies available at law or in equity, including without limitation, injunctive relief or declaratory judgment.

23-17.20-4. Effect of external appeals determination on subsequent actions. – (a) A determination in favor of a health care entity as a result of an external appeal shall create a rebuttable presumption in any subsequent action that the health care entity's prior health care treatment decision was consistent with the duty of ordinary care established pursuant to the provisions of section 27-17.20-3.

SECTION 2. Sections 23-17.12-2, 23-17.12-3, and 23-17.12-4 of the General Laws in Chapter 23-17.12 entitled "Health Care Services - Utilization Review Act" are hereby amended to read as follows:

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

(1) "Adverse determination" means any decision by a review agent not to certify a health care service. A decision by a review agent to certify 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 certify formulary and nonformulary medication.

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

(3) "Department" means the department of health.

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

(5) "Emergent health care services" has the same meaning as that meaning contained in

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

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

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

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

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

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

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

(iii) A provider.

(10) "Urgent health care services" has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42 as may be amended from time to time and includes those resources necessary to treat a symptomatic medical, mental health, or substance abuse or other health care condition requiring treatment within a twenty four (24) hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to be emergent health care services as defined in subdivision (5).

(11) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care services of a provider, given or proposed to be given to a patient or group of patients. Utilization review does not mean

elective requests for the clarification of coverage, claims review that does not include the assessment of the medical necessity and appropriateness, or a provider's internal quality assurance program except if it is associated with a health care financing mechanism.

(12) "Utilization review plan" means a description of the ~~standards governing~~ utilization review activities performed by a private review agent~~.~~ which includes the standard for medical necessity and appropriateness as defined in this section.

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

(14) “Medical necessity and appropriateness” means the standard of care which is based upon generally accepted medical practices in light of conditions at the time of treatment and which satisfies the following requirements:

(i) appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee’s condition;

(ii) compatible with the standards of acceptable medical practice in the United States;

(ii) provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;

(iv) not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital;

(v) not primarily custodial care, unless custodial care is a covered service or benefit under the eligible enrollee’s evidence of coverage; and

(vi) supported by at least two (2) forms of medical and scientific evidence as defined in this section.

(15) “Medical and scientific evidence” means:

(i) peer reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(ii) peer reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database or Health Services Technology Assessment Research (HSTAR);

(iii) medical journals recognized by the United States secretary of health and human services, under section 186(t)(2) of the social security act;

(iv) the following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, and the United States Pharmacopoeia-Drug Information; or

(v) Findings, studies, or research conducted by, or under the auspices of federal government agencies and nationally recognized federal research institutes, including without limitation, the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any national board recognized by the National Institutes of Health for the purpose of assessing the medical value of health services.

23-17.12-3. Regulation of review agents -- Certificate -- (a) A review agent shall not conduct utilization review in the state unless the department has granted the review agent a certificate.

(b) Review agents who are operating in Rhode Island prior to the promulgation of regulations pursuant to this chapter may continue to conduct utilization review until such time as the department promulgates regulations, develops required forms, and has acted on the application submitted by the review agent.

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

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

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

(f) After consultation with the payers and providers of health care, no later than one year after January 1, 1993, the department shall adopt regulations necessary to implement the provisions of this chapter including but not limited to the following:

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

(2) The circumstances, if any, under which utilization review may be delegated to any other utilization review program and evidence that such delegated agency is a certified utilization

review agency pursuant to the requirements of this chapter;

(3) A complaint resolution process, acceptable to the department whereby patients, their physicians or other health care providers may seek prompt reconsideration or appeal of adverse decisions by the review agent, as well as the resolution of complaints and other matters of which the review agent has received written notice thereof;

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

(5) The requirement that each review agent shall utilize written medically acceptable screening criteria and review procedures which are established and periodically evaluated and updated with appropriate consultation with Rhode Island licensed physicians, including practicing physicians, and other health care providers.

(6) The requirement that, other than in exceptional circumstances, or when the patient's attending physician or dentist is not reasonably available, no adverse determination that care rendered or to be rendered is medically inappropriate shall be made until an appropriately qualified and licensed review physician, dentist, or other practitioner has spoken to the patient's attending physician, dentist, or other practitioner concerning the medical care;

(7) The requirement that, upon written request made by or on behalf of a patient, any determination that care rendered or to be rendered is medically inappropriate shall include the written evaluation and findings of the reviewing physician, dentist, or other practitioner; provided, however, that the review agent is required to accept a verbal request made by or on behalf of a patient for such information where a provider or patient can demonstrate that a timely response is urgent; the verbal request must be confirmed in writing within seven (7) days;

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

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

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

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

(12) The requirement that the utilization review agent shall not impede the provision of health care services for treatment and/or hospitalization or other use of a provider's services or facilities for any patient for whom the treating provider determines the health care service to be of an emergency nature. The emergency nature of the health care service shall be documented and signed by a licensed physician, dentist, or other practitioner and may be subject to review by a review agent.

(13) The requirement that a review agent shall make a determination, and shall communicate that determination within time frames and by such means as specified by the department; and

(14) The requirement that except in circumstances as may be allowed by regulations promulgated pursuant to this chapter, no adverse determination shall be made on any question relating to health care and/or medical services by any person other than an appropriately licensed physician, dentist, or other practitioner, which determination shall be discussed by the reviewing practitioner with the affected provider or other designated or qualified professional or provider responsible for treatment of the patient.

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

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

23-17.12-4. Application -- (a) An applicant for a certificate shall:

(1) Submit an application to the director; and

(2) Pay the application fee established by the director through regulation and section 23-17.2-3(g).

(b) The application shall:

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

(2) Be signed and verified by the applicant.

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

(1) A utilization review plan that includes:

(i) ~~The standards and criteria to be utilized by the review agent, provided however, that the agent may request that the state agency regard specific portions thereof or the entire document to constitute "trade secrets" within the meaning of that term in section 38-2-2(4)(i)(B);~~ The medical necessity and appropriateness standard established in this chapter;

(ii) Those circumstances, if any, under which utilization review may be delegated to a provider utilization review program; and

(iii) A complaint resolution process, consistent with section 23-17.12-9, whereby patients, physicians or other health care providers may seek prompt reconsideration or appeal of adverse determinations by the review agent as well as the resolution of other complaints regarding the review process.

(2) The type and qualifications of the personnel either employed or under contract to perform the utilization review;

(3) The procedures and policies to ensure that a representative of the review agent is reasonably accessible to patients and providers five (5) days a week during normal business in Rhode Island and during the hours of the agency's review operations;

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

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

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

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

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

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

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

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

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

23-17.12-3. Regulation of review agents – Certificate. -- (a) A review agent shall not conduct utilization review in the state unless the department has granted the review agent a certificate.

(b) Review agents who are operating in Rhode Island prior to the promulgation of regulations pursuant to this chapter may continue to conduct utilization review until the time that the department promulgates regulations, develops required forms, and has acted on the application submitted by the review agent.

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

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

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

(f) After consultation with the payers and providers of health care, the department shall adopt regulations necessary to implement the provisions of this chapter including, but not limited to, the following:

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

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

(3) A complaint resolution process, acceptable to the department whereby patients, their physicians, or other health care providers may seek prompt reconsideration or appeal of adverse decisions by the review agent, as well as the resolution of complaints and other matters of which the review agent has received written notice;

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

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

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

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

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

(iv) All documentation regarding required consultations, including comments and/or recommendations provided by the health care providers involved in the review of the screening criteria, as well as the utilization review agent's action plan or comments on any recommendations, shall be in writing and shall be furnished to the department on request. The

documentation shall also be provided on request to any licensed health care provider at a nominal cost that is sufficient to cover the utilization review agent's reasonable costs of copying and mailing.

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

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

(6) The requirement that, other than in exceptional circumstances, or when the patient's attending physician or dentist is not reasonably available, no adverse determination that care rendered or to be rendered is medically inappropriate shall be made until an appropriately qualified and licensed review physician, dentist, or other practitioner has spoken to the patient's attending physician, dentist, or other practitioner concerning the medical care;

(7) The requirement that, upon written request made by or on behalf of a patient, any determination that care rendered or to be rendered is medically inappropriate shall include the written evaluation and findings of the reviewing physician, dentist, or other practitioner. The review agent is required to accept a verbal request made by or on behalf of a patient for any information where a provider or patient can demonstrate that a timely response is urgent. The verbal request must be confirmed, in writing, within seven (7) days;

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

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

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

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

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

facilities for any patient for whom the treating provider determines the health care service to be of an emergency nature. The emergency nature of the health care service shall be documented and signed by a licensed physician, dentist, or other practitioner and may be subject to review by a review agent.

(13) The requirement that a review agent shall make a determination and shall communicate that determination within time frames and by any means specified by the department; and

(14) The requirement that except in circumstances as may be allowed by regulations promulgated pursuant to this chapter, no adverse determination shall be made on any question relating to health care and/or medical services by any person other than an appropriately licensed physician, dentist, or other practitioner, which determination shall be discussed by the reviewing practitioner with the affected provider or other designated or qualified professional or provider responsible for treatment of the patient.

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

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

23-17.12-4. Application -- (a) An applicant for a certificate shall:

(1) Submit an application to the director; and

(2) Pay the application fee established by the director through regulation and section 23-17.2-3(g).

(b) The application shall:

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

(2) Be signed and verified by the applicant.

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

(1) A utilization review plan that includes:

(i) ~~The standards and criteria to be utilized by the review agent, provided however, that the agent may request that the state agency regard specific portions thereof or the entire document~~

~~to constitute "trade secrets" within the meaning of that term in section 38-2-2(4)(i)(B);~~ The medical necessity and appropriateness standard established in this chapter;

(ii) Those circumstances, if any, under which utilization review may be delegated to a provider utilization review program; and

(iii) A complaint resolution process, consistent with section 23-17.12-9, whereby patients, physicians or other health care providers may seek prompt reconsideration or appeal of adverse determinations by the review agent as well as the resolution of other complaints regarding the review process.

(2) The type and qualifications of the personnel either employed or under contract to perform the utilization review;

(3) The procedures and policies to ensure that a representative of the review agent is reasonably accessible to patients and providers five (5) days a week during normal business in Rhode Island and during the hours of the agency's review operations;

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

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

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

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

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

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

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

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

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

SECTION 3. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY -- MANAGED CARE LIABILITY

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This act would provide new standards and procedures governing the liability of health care entities for managed care decisions. This act would also provide for a private cause of action by an enrollee in a managed health care plan for failing to exercise ordinary care when making health care treatment decisions.

This act would take effect upon passage.

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