ARTICLE XX AS AMENDED

RELATING TO HEALTH AND SAFETY

SECTION 1. WHEREAS, the transmission and spread of COVID-19 is and is expected to continue to be a significant public health concern in Rhode Island until such time as an effective vaccine against the virus is discovered and made widely available;

WHEREAS, federal and state public health authorities largely agree that it is highly unlikely that a vaccine effective against COVID-19 will be widely available in less than twelve to eighteen months;

WHEREAS, it is imperative that health insurers issuing policies in Rhode Island continue to take and maintain timely measures to ensure access and continuity of healthcare services, including the expansion of telemedicine services;

WHEREAS, low-cost telephone and other internet-based audio-only and live video technologies are widely available and accessible to health care providers and patients. These technologies can enable the provision of health care services, including behavioral health care services, in a manner that will limit the transmission of COVID-19 to health care providers and patients while providing clinically appropriate, medically necessary health care services to those quarantined or practicing social distancing;

WHEREAS, insurance carriers have not always fully reimbursed health care providers for telemedicine services;

WHEREAS, insurance carriers have not always provided coverage for the full range of telemedicine services;

WHEREAS, broad access to telemedicine services is particularly important during the COVID-19 outbreak so that health care professionals can continue to treat patients while in quarantine and to limit exposure as a preventive measure;

WHEREAS, Medicare program guidance has been issued by the federal government during this COVID-19 pandemic to remove barriers to telemedicine/telehealth services during this crisis, and reasonable consistency among insurance plans is necessary to ensure health service access and continuity of care for patients and providers;

WHEREAS, in order to protect public health and mitigate exposure to and the spread of COVID -19, it is essential to facilitate the delivery of telemedicine services as a convenient, easily accessible, and affordable option to both health care providers and patients;

WHEREAS, during the COVID-19 pandemic, faults in our regulatory system have led to strain on our health care providers, needed care being potentially delayed or impeded and/or reimbursement for medically necessary covered services being unreasonably denied. The requirement that referrals be obtained from primary care physicians for specialty services has been applied unreasonably by at least one major health plan, putting an unnecessary burden on providers and an obstacle to accessing care for patients;

WHEREAS, unreasonable referral requirement policies should not be allowed to place unnecessary administrative burdens on providers and/or create obstacles to accessing medically necessary covered health care services for patients;

WHEREAS, the existing statutory and regulatory frameworks on benefit determination and network plans do not contemplate drastic increase in demands for health care delivery and corresponding insurance reimbursements, providers' decreased administrative bandwidth, changes in utilization patterns and anticipated streams of income, the need for alternative methods and sites of care delivery, and the anticipated shortage of available direct care workers and providers, all resulting from the COVID-19 public health emergency; and

WHEREAS, it has become clear that during the expected course of the COVID-19 pandemic, certain benefit determination requirements should be suspended or relaxed in order to better enable providers' continuing delivery of critical services and by easing and accelerating patients' access to necessary health care services.

SECTION 2. Section 27-81-3 of the General Laws in Chapter 27-81 entitled "The Telemedicine Coverage Act" is hereby amended to read as follows:

27-81-3. Definitions.

As used in this chapter:

(1) "Distant site" means a site at which a health-care provider is located while providing health-care services by means of telemedicine.

(2) "Health-care facility" means an institution providing health-care services or a health-care setting, including, but not limited to: hospitals and other licensed, inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory and imaging centers; and rehabilitation and other therapeutic-health settings.

(3) "Health-care professional" means a physician or other health-care practitioner licensed, accredited, or certified to perform specified health-care services consistent with state law.

(4) "Health-care provider" means a health-care professional or a health-care facility.

(5) "Health-care services" means any services included in the furnishing to any individual of medical, podiatric, or dental care, or hospitalization, or incident to the furnishing of that care or hospitalization, and the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

(6) "Health insurer" means any person, firm, or corporation offering and/or insuring health-care services on a prepaid basis, including, but not limited to, the Rhode Island Medical Assistance Program as contained in Chapter 40-8 and section 42-7.2-2(6) of the Rhode Island General Laws, a nonprofit service corporation, a health-maintenance organization, or an entity offering a policy of accident and sickness insurance.

(7) "Health-maintenance organization" means a health-maintenance organization as defined in chapter 41 of this title.

(8) "Nonprofit service corporation" means a nonprofit, hospital-service corporation as defined in chapter 19 of this title, or a nonprofit, medical-service corporation as defined in chapter 20 of this title.

(9) "Originating site" means a site at which a patient is located at the time health-care services are provided to them by means of telemedicine, which can ~~be~~ include a patient's home where ~~medically~~ clinically appropriate.~~; provided, however, notwithstanding any other provision of law, health insurers and health-care providers may agree to alternative siting arrangements deemed appropriate by the parties.~~

(10) "Policy of accident and sickness insurance" means a policy of accident and sickness insurance as defined in chapter 18 of this title.

(11) "Store-and-forward technology" means the technology used to enable the transmission of a patient's medical information from an originating site to the health-care provider at the distant site without the patient being present.

(12) Effective January 1, 2022, "Telemedicine" means the delivery of clinical health-care services by means of real time, two-way electronic audiovisual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, treatment, and care management of a patient's health care while such patient is at an originating site and the health-care provider is at a distant site, consistent with applicable federal laws and regulations. Effective January 1, 2022, "Telemedicine" does not include an audio-only telephone conversation, email message, or facsimile transmission between the provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions.

Through December 31, 2021, "Telemedicine" shall mean the delivery of clinical health-care services by means of real time, two-way electronic audiovisual or telephone-audio-only communications, including the application of secure video conferencing or store-and-forward technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, treatment, and care management of a patient's health care while such patient is at an originating site and the health-care provider is at a distant site, consistent with applicable federal laws, regulations and guidance. Through December 31, 2021, "Telemedicine" does not include an email message, text message, or facsimile transmission between the provider and patient, or an automated computer program used to diagnose and/or treat ocular or refractive conditions.

SECTION 3. Section 27-81-4 of the General Laws in Chapter 27-81 entitled "The Telemedicine Coverage Act" is hereby amended to read as follows:

27-81-4. Coverage of telemedicine services.

(a) Each health insurer that issues individual or group accident-and-sickness insurance policies for health-care services and/or provides a health-care plan for health-care services shall provide coverage

for the cost of such covered health-care services provided through telemedicine services, as provided in this section.

(b) ~~A~~ Effective January 1, 2022, a health insurer shall not exclude a health-care service for coverage solely because the health-care service is provided through telemedicine and is not provided through in-person consultation or contact, so long as such health-care services are ~~medically~~ clinically appropriate to be provided through telemedicine services and, as such, may be subject to the terms and conditions of a telemedicine agreement between the insurer and the participating health-care provider or provider group.

Through December 31, 2021, a health insurer shall not exclude a health-care service for coverage solely because the health-care service is provided through telemedicine and is not provided through in-person consultation or contact, so long as such health-care services are clinically appropriate to be provided through telemedicine services. The determination of the clinical appropriateness of a health-care service to be provided through telemedicine shall include taking into consideration any existing public health emergency or public health recommendations. The determination of the clinical appropriateness of a health-care service to be provided through telemedicine may vary for health care services provided through audio-visual telemedicine versus health care services provided through audio-only telemedicine.

(c) Effective January 1, 2022, ~~B~~benefit plans offered by a health insurer may impose a deductible, copayment, or coinsurance requirement for a health-care service provided through telemedicine.

Through December 31, 2021, benefit plans offered by a health insurer shall not impose a deductible, copayment, or coinsurance requirement in excess of what would normally be charged for a primary care visit for a health-care service provided in-network through telemedicine This requirement does not apply to deductibles, copayments, or coinsurance requirements for health-care services provided out-of-network through telemedicine and, to the extent prohibited by federal law, regulation or guidance, shall not apply to high deductible plans.

(d) Through December 31, 2021, clinically appropriate, medically necessary telemedicine services delivered by in-network providers shall not be subject to prior authorization or referral requirements.

(e) Through December 31, 2021, clinically appropriate, medically necessary telemedicine services delivered by in-network providers shall be reimbursed at rates not lower than services delivered through traditional (in-person) methods.

(f) Through December 31, 2021, except for requiring compliance with applicable state and federal laws, regulations and/or guidance, no health insurer shall impose any specific requirements as to the technologies used to deliver clinically appropriate, medically necessary telemedicine services.

(g~~d~~) The requirements of this section shall apply to all policies and health plans issued, reissued, or delivered in the state of Rhode Island on and after January 1, 2018.

(h~~e~~) This chapter shall not apply to: short-term travel, accident-only, limited or specified disease; or individual conversion policies or health plans; nor to policies or health plans designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare; or any other similar coverage under state or federal governmental plans.

SECTION 4. Chapter 27-81 of the General Laws entitled “The Telemedicine Coverage Act” is hereby amended by adding thereto the following sections:

27-81-6. Reporting.

Each health insurer shall collect and provide to the Office of the Health Insurance Commissioner (Office), in a form and frequency acceptable to the Office, information and data reflecting its telemedicine policies, practices and experience.

27-81-7. Rules and Regulations.

a. The health insurance commissioner may promulgate such rules and regulations as are necessary and proper to effectuate the purpose and for the efficient administration and enforcement of this chapter except with regard to the Rhode Island Medical Assistance Program as contained in Chapter 40-8 and section 42-7.2-2(6) of the Rhode Island General Laws.
b. The director of the Executive Office of Health and Human Services may promulgate such rules and regulations as are necessary to effectuate the purpose and for the efficient administration and enforcement of this chapter as it relates to the Rhode Island Medical Assistance Program as contained in Chapter 40-8 and section 42-7.2-2(6) of the Rhode Island General Laws.
c. The director of the department of health may promulgate such rules and regulations for providers as are necessary and proper to best ensure that, consistent with the purpose of this chapter, only clinically appropriate health care services are provided by telemedicine.

SECTION 5. Section 27-18.8-3 of the General Laws in Chapter 27-18.8 entitled “Health Care Accessibility and Quality Assurance Act” is hereby amended to read as follows:

27-18.8-3. Certification of network plans.

(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; and

(8) As to each network plan that imposes any referral requirements as a condition to coverage and or reimbursement, the health care entity shall maintain policies and procedures to ensure that its referral requirements do not impede access or continuity of care for beneficiaries or create unreasonable denials of coverage or reimbursement for medically necessary covered services, including without limitation by adopting policies and procedures to allow for required referrals to be submitted

retroactively for a minimum of ninety (90) days from date of service, without denial of coverage or reimbursement.

(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.

SECTION 6. Chapter 27-18.9 of the General Laws entitled “Benefit Determination and Utilization Review Act” is hereby amended by adding thereto the following section:

27-18.9-16. Temporary benefit determination review requirements during the COVID-19 Pandemic.

(a) Through December 31, 2021, health care entities and, where applicable, review agents shall suspend prior authorization requirements for all in-network non-pharmacy COVID-19 related diagnostic and treatment services, including behavioral health services reasonably related to the COVID-19 pandemic;

(b) Through December 31, 2021, health care entities and, where applicable, review agents shall not replace prior authorization requirements suspended pursuant to paragraph (a) above with new retrospective review requirements;

SECTION 7. This article shall take effect upon passage.