230-RICR-20-30-9

TITLE 230 – DEPARTMENT OF BUSINESS REGULATION

CHAPTER 20 – INSURANCE

SUBCHAPTER 30 – HEALTH INSURANCE

Part 9 – Network Plans

9.1 Authority

These rules and regulations are promulgated pursuant to R.I. Gen. Laws § 27-18.8-1 *et seq*., entitled the Health Care Accessibility and Quality Assurance Act (the Act).

9.2 Purpose and Scope

A. It is in the best interest of the public that those individuals and health care entities involved with the delivery of network plan coverage in our state meet the standards set forth in R.I. Gen. Laws § 27-18.8-1 *et seq*. and any regulations promulgated thereunder to ensure accessibility and quality for the state's patients; and

B. Nothing in this Act and these regulations is intended to prohibit a health care entity from forming limited networks of providers.

9.3 Definitions

A. As used in this regulation:

1. "Active treatment" means;

    a. An ongoing course of treatment for a life-threatening condition;

    b. An ongoing course of treatment for an acute medical, behavioral health, dental, vision or other clinical condition;

    c. The second or third trimester of what has been documented as a non-high-risk pregnancy; and/or

    d. An ongoing course of treatment for a health condition which a treating provider substantiates that discontinuing care by that provider would worsen the condition or clinical outcome of that beneficiary.

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

    a. "Administrative adverse benefit determinations," meaning any adverse benefit determination that does not require the use of medical judgment or clinical criteria such as a determination of an individual's eligibility to participate in coverage, a determination that a benefit is not a covered benefit, a determination that an administrative requirement was not followed or any rescission of coverage; and;

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

3. "Appeal" or "Internal appeal" means a subsequent review of an adverse benefit determination upon request by a claimant to include the beneficiary or provider to reconsider all or part of the original adverse benefit determination.

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

5. "Beneficiary" means a policy holder subscriber, enrollee, or other individual participating in a health benefit plan.

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

7. "Certificate" means a certificate granted by the Commissioner to a health care entity meeting the requirements of this chapter.

8. “Commissioner" means the Commissioner of the Office of the Health Insurance Commissioner.

9. "Complaint" or "Grievance" means an oral or written expression of dissatisfaction by a beneficiary, authorized representative, or provider. The appeal of an adverse benefit determination is not considered a complaint or grievance.

10. “Covered service" or "Covered benefit" means those health care services to which a beneficiary is entitled under the terms of the health benefit plan.

11. “Delegate" means a person or other party authorized pursuant to a delegation of authority or directly or re-delegation of authority, by a health care entity or network plan to perform one or more of the functions and responsibilities of a health care entity and/or network plan set forth in the Act or regulations or guidance promulgated thereunder.

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

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

14. “Health care entity" means an insurance company licensed, or required to be licensed, by the state of Rhode Island or other entity subject to the jurisdiction of the Commissioner or the jurisdiction of the department of business regulation that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, without limitation: a for-profit or nonprofit hospital, medical or dental service corporation or plan, a health maintenance organization, a health insurance company, or any other entity providing health insurance, accident and sickness insurance, health benefits, or health care services. Entity shall have the same meaning as health care entity for purposes of these regulations.

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

16. "Material change" means a substantial systemic change determined by the Office, that could reasonably be expected to adversely affect the

access, availability, quality or continuity of services for a significant number of beneficiaries of a health care entity to include, but not limited to the following:

a. Termination of a hospital or facility contract;

b. Termination of professional provider contract(s);

c. Professional provider contract changes affecting any one professional provider specialty within any of the health care entity's network plans;

d. A change to the tiered products, multi-tiered, layered or multi-level network plan structures during a network plan contract year;

e. Termination or transition of any Benefit Determination delegate;

f. Surrender or withdrawal of any network plan holding a certificate under the Act or these regulations; or

g. Other operational and network plan changes that meet the definition of material change.

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

18. "Network" means the group or groups of participating providers providing health care services under a network plan.

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

20. "Office" means the Office of the Health Insurance Commissioner.

21. "Participating provider" or "Network provider" means a provider under contract with a health care entity, or one of its delegates, who has agreed under this contract to provide health care services to the health care entity's beneficiaries with an expectation of receiving payment, other than coinsurance, copayments, or deductibles from the beneficiary, only from the health care entity under the terms of the contract.

22. "Professional provider" means an individual provider or health care professional licensed, accredited, or certified to perform specified health

care services consistent with state law and who provides these health care services and is not part of a separate facility or institutional contract.

23. "Provider" means a physician, hospital, professional provider, pharmacy, laboratory, dental, medical, or behavioral health provider, or other state-licensed or other state-recognized provider of health care or behavioral health services or supplies.

24. "Substantial systemic change" means any modification of a health care entity's network plan's contracting, credentialing, operational policies and/or procedures relevant to these regulations adversely affecting beneficiaries, a group of providers, an entire specialty provider type, a hospital, a facility provider, or a delegate having responsibilities, or any other health care entity's modification relevant to these regulations that may impact a significant portion of its beneficiaries' access to a network provider, the availability of network providers, or the quality and continuity of care.

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

9.4 General Requirements - Certification, Recertification, and Material Change

A. A health care entity operating a network plan shall:

1. Not enroll consumers into its plan unless the Commissioner has certified the network plan pursuant to the Act and these regulations;

2. Be required to submit a recertification application every two (2) years in form and content consistent with instructions by the Office for that purpose;

3. Notify the Office at least thirty (30) calendar days prior to any substantial systemic change to any of its certified network plans; and

4. Upon a determination by the Office that a substantial systemic change constitutes a material change, file an application consistent with instructions and requests for information issued by the Office for that purpose.

B. A health care entity applying for certification, recertification or material change approval shall provide information to the Office sufficient to enable the Office to determine/evaluate compliance with the requirements of the Act and these

regulations according to instructions issued as a guidance document by the Office for that purpose.

C. The cost of the application processes (certification, recertification, and material change), application reviews, complaint processing, investigations, and other activities related to obtaining and maintaining network plan certifications shall be borne by the health care entities, as determined by the Commissioner, including:

1. An application fee established by the Commissioner for each application processed, not to exceed five hundred dollars ($500), which fee must accompany each application.

2. The total cost of obtaining and maintaining a certificate under this Act and in compliance with the requirements of the applicable rules and regulations shall be borne by the applicant and shall include one hundred and 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.

3. 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.

4. The Commissioner may not issue a certification, recertification, approval of a material change, or may suspend a currently certified network plan, if a health care entity fails to pay any of the fees, assessments and costs noted above in a timely manner.

9.5 Delegate Requirements

A. A health care entity must provide evidence to the Office of current state certification under the Act for each of its delegates, if any, to which the health care entity has delegated activity as defined in R.I. Gen. Laws Chapters 27-18.9 and/or 27-18.8.

B. A health care entity must maintain regular and meaningful oversight of each of its delegates to ensure every such delegate is in compliance with the Act's network plan requirements, including but not limited to the following:

1. For any portion of the health care entity’s network plan activity that is delegated, in part or whole, the health care entity shall be responsible for oversight and be held accountable for all activity delegated and for any non-compliance of its delegate with the Act and these regulations.

2. Should the Commissioner determine that any delegated activity is non-compliant with the rules herein or other state and/or federal laws, the health care entity may be required by the Commissioner to re-assume or reassign the performance of the activity delegated.

3. The health care entity shall ensure through its delegation agreement or contract that it and the Office will have direct access to all the information held by the delegate that in its or the Office's determination could contribute to determining compliance with the Act and these regulations.

9.6 Network Plan General Requirements

A. For each network plan the health care entity must maintain and submit to the Office its most current grievance and complaint process that adheres to and includes the following minimal requirements:

1. Written processes whereby the beneficiary, a beneficiary's authorized representatives, or health care providers may seek resolution of complaints and other matters of which the health care entity has received oral or written notice;

2. Reasonable timeframes for the resolution of beneficiary, authorized representative of beneficiary, and provider complaints, grievances inquiries of not more than thirty (30) calendar days from the date the health care entity receives the oral or written notice unless granted an extension by the Commissioner;

3. At a minimum, an annual communication from the applicable health care entity to the network plan's beneficiaries and providers that explains the grievance and complaint process for the applicable network plan(s) and provides guidance for distinguishing between a complaint/grievance and a benefit determination appeal and the rights associated with each; and

4. Internal monitoring of complaints and grievances and reporting to the Office on categories of complaints in form and content consistent with instructions issued by the Office for that purpose.

B. As to each network plan, a health care entity shall be required to submit to the Office a mechanism designed to ensure beneficiaries and providers, including local providers participating in the network plans, provide meaningful input into the plan's health care polices, including without limitation:

1. A process to evidence that beneficiary and provider input is reasonably assessed for use by the health care entity; and

2. A process that ensures that issues brought to the attention of the health care entity regarding its network plans via the entity's complaint processes are regularly considered and addressed by the health care entity in the context of developing, reviewing and evaluating each network plan's health care policies.

C. For each network plan, health care entities must evidence to the Office its adherence to the following formulary requirements:

1. Network plan providers shall have input to formulary development;

2. "Formulary changes" include but are not limited to the following:

    a. Medications covered on the formulary;

    b. Medication tiering; and

    c. Cost sharing.

3. Prior to making any formulary changes for a network plan, a health care entity must provide at least thirty (30) calendar days direct notice to prescribers of the affected medications and adversely affected beneficiaries must be given at least thirty (30) calendar days direct notice prior to effective date of change;

4. All formulary change notifications to beneficiaries must include the following:

    a. The familiar name of the medication(s);

    b. A description of the change being made in easy to understand language; and

    c. An explanation of the formulary exception process, in accordance with R.I. Gen. Laws Chapter 27-18.9, in easy to understand language; and

D. To the extent a network plan has requirements relating to referrals, the network plan and or health care entity must institute and maintain a procedure for providers to make and authorize in-network referrals, which procedure shall include, without limitation:

1. A reasonable process for communicating the referral process to its beneficiaries in a manner that is easily understood; and

2. An administrative appeal process for denials for failure to obtain a referral consistent with R.I. Gen. Laws Chapter 27-18.9.

E. Each health care entity shall develop, implement and maintain a quality assurance program that: includes the health care entity's oversight of all activities, whether or not delegated, subject to the Act and these regulations; that includes a process to regularly evaluate and determine whether its activities are being performed in a manner that maintains the quality of services delivered to its beneficiaries; and that assures that these activities do not adversely affect the delivery of covered services.

F. Each health care entity shall evidence to the Offices its compliance with state and federal behavioral health parity statutes and any applicable regulations.

G. Each health care entity shall cooperate with all compliance reviews and investigations conducted by the Office which may include but not be limited to the following:

1. A review by the Office of the certified health care entity's operations as often as the Commissioner in his or her sole discretion deems appropriate to determine whether a health care entity may be in violation of the Act and these regulations.

9.7 Network Adequacy Requirements

A. For each Network Plan a health care entity must submit to the Office the Network Adequacy policies and procedures that evidence adherence to the following:

1. Each health care entity shall have an ongoing process in place to monitor and assure that its provider network for each of its network plans are sufficient in scope and volume to assure address and monitor its population needs that all covered services for beneficiaries, including children, adults and low-income, medically underserved beneficiaries, children and adults with serious chronic and/or complex health conditions or physical and/or mental disabilities and persons with limited English proficiency are accessible in a timely manner without unreasonable delay.

2. Beneficiaries have access to emergency services twenty-hours (24) hours a day, seven (7) days a week.

3. The health care entity has clear procedures in place that assure its network plan beneficiaries access to a provider in the event that the health care entity fails to maintain sufficient provider contracts, or a network provider is not available to provide covered services to beneficiaries in a timely manner. These procedures must include:

a. A description of the circumstances in which the member is held harmless in the event that a network provider is not available to provide the covered benefit without unreasonable travel or delay;

b. A process to appeal a denial of access to an out of network provider and/or any additional cost shares imposed beyond the beneficiary's in-network coverage, in accordance with R.I. Gen. Laws Chapter 27-18.9;

c. A process to address network inadequacies when the Commissioner has determined that the network plan has not maintained sufficient provider contracts.

4. A documented method to inform and assist beneficiaries on how to:

    a. Choose and/or utilize a Network Plan;

    b. Select and change a provider;

    c. Access an updated provider directory in each network plan; and

    d. Inform the beneficiary on the use of tiered networks within a network plan to include changes in beneficiaries' financial liability.

B. Each health care entity shall establish a process to monitor its network plan's network adequacy on quarterly basis. Information to substantiate this process shall be made available to the Office upon request.

C. Health care entities must provide evidence to the Office of adherence to the following transition of care requirements:

1. The network plan has established and maintains a transition of care policy and procedure for use in the event of a network plan change that affects beneficiaries including but not limited to the following types of network plan changes:

    a. Narrowing of an existing network plan;

    b. Network tiering or changes in network tiering of an existing network plan;

    c. Termination of providers in a network plan with beneficiaries in active treatment; and

    d. New beneficiaries in active treatment.

D. Health care entities shall evidence and maintain the following, to the satisfaction of the Commissioner, regarding network plan provider directories for each network plan.

1. A mechanism to submit provider directories to the Office for review.

2. A process to make the provider directories easily available by the health care entity to consumer and providers in an understandable and reasonably comprehensive format:

    a. Location(s) by city, town and county;

    b. Providers' Service Category (e.g. physician practice, urgent care, radiology, behavioral health, laboratory, pharmacy, telehealth etc.);

    c. For professional provider directories;

(1) Specialty practice/practice type;

(2) If provider is accepting new patients;

(3) Hospital admitting privileges (if applicable) or affiliation with in-network facilities;

(4) Network plan identification and tiering (if applicable) in language easy to understand;

3. That provider directories are available to beneficiaries, providers, and the public according to the following formats:

a. Electronically with search functions;

b. Printed and paper to be made available upon request to a beneficiary or a prospective beneficiary; and

c. Must accommodate individuals with limited English proficiency and/or those with disabilities.

4. Electronic and paper directories must be updated at least monthly with daily updates available telephonically and according to § 9.7(D)(3) of this Part above.

5. Contact information in order to access an updated directory must be referenced on the health care entity website and on the beneficiary's insurance/health plan card.

9.8 Professional Provider Credentialing and Re-credentialing

A. Each health care entity's professional provider credentialing and re-credentialing requirements, policies and processes must be submitted to the Office and must adhere, at a minimum, to the following.

1. Each professional provider credentialing application shall be reviewed by the health care entity's credentialing body; however, the credentialing body may delegate to one or more of its members decision making authority.

2. Professional provider credentialing and re-credentialing criteria shall include:

a. Input from providers credentialed in the entity's network plans and the criteria developed shall be available to applicants;

b. That any economic considerations taken into account by the health care entity factor in and/or adjust for applicant's specialty,

applicant's utilization and practice patterns, comparison of the applicant to peers in same specialty, applicant's case mix, severity of illness and/or age of the applicant's patients, and any features of an applicant's practice that may account for higher or lower than expected costs; and

c. That any economic profiling used as part of credentialing or re-credentialing be made available to those provider's profiled.

3. Each health care entity shall evidence to the Office compliance with R.I. Gen. Laws §§ 27-18-83, 27-19-74, 27-20-70, and 27-41-87 that include the following:

a. Communication to the applicant of its credentialing and re-credentialing decision as soon as practical, but no later than forty-five (45) calendar days after the date of receipt of a completed application.

b. For minor changes to the demographic information of a professional provider who is already credentialed with a health care entity, evidence that the health care entity shall complete such change within seven (7) business days of receipt of the health care provider's request. Minor changes shall include, but not be limited to, changes of address and changes to a health care provider's tax identification number.

c. Each health care entity or network plan shall establish a written standard acceptable to the Commissioner defining what elements constitute a complete credentialing and re-credentialing application and shall distribute this standard with the written version of the credentialing application and make such standard available on its website.

4. During the re-credentialing process, if applicable, network plans must have an established mechanism to assure effective communications with in-network professional providers, including without limitation:

a. A two-way communication to assure that the health care entity has directly informed the provider of the need for re-credentialing;

b. Adequate due diligence by the health care entity in obtaining the current and correct mailing address or other provider-preferred mode of communication to directly communicate with the network provider;

c. A mechanism to adequately follow up with network providers who have not responded to the initial re-credentialing communications with a diligent effort to validate the provider's current physical

and/or electronic address used as the mode of communication and confirm receipt of the initial re-credentialing communication; and

d. Health care entities and/or network plans shall not de-credential a network provider if the health care entity has failed to properly adhere to these re-credentialing requirements.

5. Each health care entity or network plan shall promptly respond to inquiries by the applicant regarding the status of a credentialing or re-credentialing application as well as provide the applicant with an automated application status update at least once every fifteen (15) calendar days to inform the applicant of any missing application materials until the application is deemed complete; and

6. Within five (5) business days of deeming an application complete each health care entity or network plan shall inform the applicant that the credentialing or re-credentialing application is complete.

7. The effective date for billing privileges shall be the next business day following the date of approval of a credentialing application.

B. Evidence to the Office that if the health care entity denies a credentialing or re-credentialing application, the health care entity or network plan shall notify the health care provider in writing and shall provide the health care provider with any and all reasons for denying the application.

C. A health care entity shall establish a transitional or conditional credentialing approval processes in any provider category where there is an established "need" (geographic "need" or "need" by specialty type such as resident graduates, primary care providers, behavioral health providers or certain specialist providers), and shall include:

1. "Need" shall be assessed by the Commissioner considering continuity of care for beneficiaries, insufficient network by provider type and/or the inability of the entity to provide timely access to covered services to its beneficiaries.

2. To be considered for a transitional or conditional credentialing approval, the provider must have:

a. Submitted an otherwise completed credentialing application and met all other credentialing criteria;

b. Successfully graduated from the training program; and

c. Includes a mechanism to ensure that providers with transitional, conditional or temporary credentialing approval receive an effective

date for billing privileges of the first business day after the transitional, conditional and/or temporary credentialing approval.

D. A credentialing application and a re-credentialing application, if applicable shall be considered complete when all the following requested material has been submitted and the health care entity or network plan may not require the submission of additional material for an application to be considered complete unless any such additional requirement is approved by the Commissioner:

1. Provider demographics to include name, current mailing address;

2. Current valid license, registration or certificate required in order for professional provider to practice in Rhode Island or other state as applicable;

3. History of any revocation, suspension, probationary status or other disciplinary action regarding provider's license, registration or certificate noted in § 9.8(D)(2) of this Part above;

4. Clinical privileges at a hospital, as applicable;

5. Valid Drug Enforcement Agency and Controlled Substance certificate/registration and/or other state or federal verification to prescribe controlled substances (if applicable);

6. Evidence of board certifications if the professional provider states that he/she is board certified;

7. Evidence of malpractice/professional liability insurance; and

8. History of professional liability claims and description of any settlements or judgements paid to a claimant in connection with a professional liability claim.

E. A health care entity may utilize an alternative credentialing program approved by the Commissioner.

9.9 Provider Contracting and Due Process

A. The health care entity must include the following in its network provider contracts:

1. A provision protecting beneficiaries to include:

a. Ensuring the beneficiary is held harmless from any financial liability beyond in-network cost shares attributable to the failure of a referring network provider to adhere to the referral process, including by failing to submit the required network plan’s referral documents according to the health care entity requirements when

there is evidence that the beneficiary sought and received a referral from the network provider. This section is not applicable in cases where the beneficiary has self-referred.

b. That in no event, including but not limited to non-payment by the health care entity or intermediary, insolvency of the health care entity or one of its delegates or breach of the health care entity's agreement with a network plan provider, shall the network plan provider bill, charge, collect a deposit from, or seek compensation, remuneration or reimbursement from a beneficiary to include but not limited to facility or administrative fees added to a beneficiary for covered services by the provider; and

c. That no beneficiary shall be liable to any provider for charges for covered benefits, except for the amounts due for co-payments, deductibles and/or coinsurance, when provided or made available to enrolled participants by a licensed health maintenance organization, as that term is defined in R.I. Gen. Laws § 27-41-2(t), during a period in which premiums were paid by or on behalf of the enrollee.

2. Language to describe that in the event of a provider contract termination:

a. The beneficiary is held harmless for covered benefits except for amounts due for co-payments, coinsurance, and deductibles, for the duration of an active course of treatment or up to one year, whichever is earlier, subject to all the terms and conditions of the terminated provider contract, unless the provider is able to safely transition the patient to a network provider; and

b. For this period of active treatment, the beneficiary shall only be responsible for in-network cost shares provided for under the beneficiaries' coverage documents and not otherwise prohibited by state or federal laws or regulations.

B. In the event a health care entity or network plan modifies a professional provider contract the health care entity shall comply with the following:

1. 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 and any change or modification meets all requirements herein.

2. The entity or network plan shall give the professional provider an opportunity to amend or terminate the contract within sixty (60) calendar days of receipt of the notice of a contractual modification.

3. Any termination of a professional provider contract made as a result of a modification shall be effective fifteen (15) calendar days from the mailing of a written notice of termination by a professional provider to the health care entity.

4. The termination due to a modification in a professional provider contract shall not affect the method of payment or reduce the amount of reimbursement to the provider by the health care entity for any beneficiary in active treatment for an acute medical condition at the time the beneficiary's provider terminates until the active course of treatment is concluded or, if earlier, one year after the termination.

C. For all adverse decisions resulting in a change of professional provider privileges or a change in the terms of a provider contract, health care entities shall afford due process that includes, without limitation, the following:

1. Option for a voluntarily waiver by the professional provider;

2. Written notification by the health care entity to the affected professional provider(s) of the proposed action(s) and the reasons for the proposed action(s);

3. Meaningful opportunity for the provider to contest the proposed action(s);

4. An appeals process that has reasonable time limits for the resolution of the appeal; and

5. That all due process decisions are made by an objective, unbiased, and qualified individual or group.

D. A health care entity shall not refuse to contract with or compensate for covered services an otherwise eligible participating or non-participating provider solely because that provider has, in good faith, communicated with one or more or his/her patients regarding the provisions, terms, or requirements of the health care entity’s network plan at it relates to the needs of a patient.

E. A health care entity shall not exclude a professional provider of covered services from participation in its network plans solely based on the professional provider’s:

1. Degree or license as applicable under state law; or

2. Lack of affiliation with, or admitting privileges at, a hospital, if that lack of affiliation is due solely to provider’s type of license.

3. Discussion with a beneficiary specific treatment options or for advocating to the health care entity treatment options for a beneficiary.

F. A health care entity shall not discriminate against providers when establishing its provider networks or when establishing provider network tiers using, but not limited to, the following selection criteria:

1. The provider treats a substantial number of patients who require expensive or uncompensated care; or

2. Are located in geographic areas that contain population or providers presenting a risk of higher than average utilization.

G. Health care entities shall not be allowed to include clauses in a provider's contract that allow for the health care entity's termination of the contract "without cause"; provided however, "cause" shall include lack of need due to economic considerations.

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

9.10 Reporting

A. Each health care entity shall compile and maintain reports in form and content consistent with instructions issued as a bulletin by the Office for that purpose and these reports shall:

1. Include but not be limited to a report that includes all complaints received by the health care entity and its delegates (if applicable) by complaint categories set forth by the Office, which categories may change from time to time at the discretion of the Commissioner; and;

2. Be filed with the Office at least annually on or before March 1st of each calendar year.

B. Each health care entity shall promptly comply with periodic requests by the Commissioner and/or the Office for information, data and/or reports requested by the Commissioner for the purpose of determining compliance with the Act and these regulations.

9.11 Denial, Suspension, or Revocation of Certification

Denial, suspension, or revocation of certification is governed by R.I. Gen. Laws § 27-18.8-8.

9.12 Penalties and Enforcement

Penalties and enforcement is governed by R.I. Gen. Laws § 27-18.8-9.

9.13 Rules of Governance

All hearings and reviews required under the provisions of the Act, as amended, shall be held in accordance with the provisions of Part 10-00-2 of this Title.

9.14 Severability

If any section, clause, or provision of the Act or these regulations shall be held either unconstitutional or ineffective in whole or in part, to the extent that it is not unconstitutional or ineffective, it shall be valid and effective, and no other section, clause or provision shall on account thereof be termed invalid or ineffective.