

# RHODE ISLAND DEPARTMENT OF HEALTH

## Health Plan Application Guidelines

The Rhode Island Department of Health (Department) provides the *Health Plan Application Guidelines* as an outline for the health plan application process, but these Guidelines do not replace or supersede Rhode Island General Laws 23-17.13 and 23-17.12, or their accompanying Rules and Regulations, R23-17.13-CHP (HP) and R23-17.12-UR (UR).

REQUIRED ELEMENTS FOR A COMPLETE HEALTH PLAN APPLICATION	
Health care entities with total Rhode Island enrollment of less than 5,000	Application & Assurances Forms Only (I.)
Health care entities with total Rhode Island enrollment between 5,000 & 10,000 & RIte Care and Medicare health plans	All of the Following Requirements Except Disclosure of Information (I., III., and IV.)
Health care entities with total Rhode Island enrollment of more than 10,000	All of the Following Requirements (I., II., III., and IV.)

**ALL APPLICATIONS MUST BE FORMATTED ACCORDING TO THE FOLLOWING OUTLINE TO BE CONSIDERED FOR CERTIFICATION / RE-CERTIFICATION:**

### I. HEALTH PLAN APPLICATION INFORMATION

Please provide the following for **each** health plan applying for certification / re-certification.

**TAB A: Application Information**

- \$500 application fee submitted with the health plan application(s) and made payable to “General Treasurer, State of Rhode Island” [HP 2.2.1]
  - Note:** In addition to the initial \$500 application fee, the Department will bill the health care entity monthly for time spent on activities related to maintaining the certification. [HP 2.2.1; HP 2.2.3 a)]
- completed *Application for Health Plan Certification / Re-certification* form(s) [HP 2.1]
  - ownership listing & description as described on the *Application for Health Plan Certification / Re-certification* form [HP 2.1]
  - description of the health plan(s), as described on the *Application for Health Plan Certification / Re-certification* form [HP 2.1]
  - copies of any and all contracts/agreements where entity contracts out, carves out, or delegates health plan/utilization review services to another organization (e.g., mental health, substance abuse, pharmacy, vision, dental, utilization review) [HP 2.6]
- completed *Application for Health Plan Certification / Re-certification Assurances* form(s) [HP 2.1]
- completed *Mandatory Addendum to License Application* [RIGL 5-75]

## II. CONSUMER DISCLOSURE INFORMATION

Please refer to the *Instructions for Consumer Documents* for submission to and approval from the Department. Health plans must follow the standardized format, *Consumer's Right to Know About Health Plans in Rhode Island*, available on the Department's website, [www.health.ri.gov/hsr/managed/man\\_care.htm](http://www.health.ri.gov/hsr/managed/man_care.htm)

### TAB B: Disclosure of Information

- the mechanism for the direct distribution of the *Consumer's Guide to Health Plans in Rhode Island* and the *Consumer's Right to Know About Health Plans in Rhode Island* disclosure documents [HP 4.1; HP 4.2]
- notification of the health plan's Internet address for public access to the consumer disclosure information [HP 4.1.2 a)]
- paper copies of the *Consumer's Right to Know About Health Plans in Rhode Island* for each health plan for which you are applying for certification [HP 4.1]

## III. POLICIES AND PROCEDURES

Please provide copies of written, approved, and operational policies and procedures that comply with the following, for the health plan(s) applying for certification / re-certification. If the entity utilizes the same policies and procedures for all health plan(s) applying for certification / re-certification, only one set of the entity's policies and procedures is required.

### TAB C: Roles and Responsibilities

- a health plan must have a mechanism to measure enrollee satisfaction and maintain satisfaction measures [HP 4.3.20]
- a health plan must maintain oversight & accountability for all delegated activity through a formal agreement describing the delegated function(s) and oversight program [HP 2.6]
- the responsibilities under the direction of the medical director include [HP 3.4]:
  - [HMO only] arrangement for the provision of health care services to enrollees [HP 3.4.1]
  - [HMO only] coordination, supervision, & functioning of professional services [HP 3.4.2]
  - [HMO only] achievement & maintenance of the quality management of professional practices through peer review mechanisms [HP 3.4.3]
  - review of each quality of care complaint [HP 6.9.4 a)]

### TAB D: Availability & Accessibility of Services

- standards ensuring reasonable provider availability and accessibility in all geographic areas where the health plan has enrollees for the following [HP 6.1.1]:
  - urgent health care services within 24 hours of request [HP 6.1.3]
  - [HMO only] timeframes for preventive services, specific to age and gender [HP 6.1.4]
  - routine health care services [HP 6.1.5]
  - a mechanism that enables enrollees to obtain timely information for accessing health care services [HP 6.1.6]
- an emergency health care services policy that outlines:

- immediate emergency health care services [HP 6.1.2]
- the criteria for accessing emergency health care services [HP 6.1.2; 6.6.2]
- the process for responding to the request of the treating provider for authorization of post-stabilization treatment [HP 6.6.1]
- the payment of examinations to determine if emergency health care services are necessary [HP 6.6.3]
- a mechanism for the distribution of a comprehensive list of participating providers to enrollees at least annually, whenever revised/updated, or upon request [HP 6.2]
  - provide a copy of the health plan's participating provider directory [HP 6.2.1]
- published phone number(s) so an enrollee can confirm the current status of any participating provider [HP 6.2.2 c)]

**TAB E: Continuity of Care**

- mechanism to provide continuity of care to enrollees [HP 6.3]
- in the event of contractual changes with participating providers, enrollees may transfer their care to an alternate participating provider in the same/similar specialty [HP 6.3.1]
- transition of care in accordance with section 5.14.2 [HP 6.3.2]
- coverage of necessary health care services 24 hours/day, 7 days/week [HP 6.3.3]

**TAB F: Quality Management Program**

- review of health plan processes on an ongoing basis [HP 6.4]
- monitor the quality of patient outcomes [HP 6.4.1]
- collect data to track the quality of clinical care received by enrollees [HP 6.4.2]
- routine reporting of results of quality management program activities to administration, providers, and the Department [HP 6.4.3]
- review medical/health records to evaluate the quality of clinical care [HP 6.4.4]
- investigate and address quality of care complaints in accordance with section 6.9 [HP 6.4.5]
- initiate remedial action for correction of deficiencies regarding individual providers, organizational performance, or whenever inappropriate or substandard services have been provided or needed services failed to be provided [HP 6.4.6]
- [HMO only] a quality management program accredited by an organization acceptable to the Department
  - provide evidence of current NCQA accreditation [HP 6.4.7]
- review of quality of care complaints by the health plan's medical director [HP 6.9.4 a)]
- review of quality of care complaints by a quality assurance committee [HP 6.9.4 b)]

**TAB G: Complaints**

- identify, evaluate, resolve, follow-up on, track, and document potential and actual problems in a timely manner [HP 6.9.1]
- recommendations to address identified problems [HP 6.9.2]
- compliance with R23-17.12-UR for complaints related to utilization review [HP 6.9.3]
- review of quality of care complaints by the health plan's medical director [HP 6.9.4 a)]
- review of quality of care complaints by a quality assurance committee [HP 6.9.4 b)]
- inform complainant of the review findings within 60 business days of receipt of the necessary information [HP 6.9.4 c)]
- notify complainants of their right to notify Department if they are not satisfied with the outcome of the health plan's internal complaint/appeal processes [HP 6.9.4 d)]

**TAB H: Confidentiality**

- mechanism to ensure the confidentiality of health care record information in the possession/control of the health plan, its employees, its agents, and parties with whom any contractual agreement exist [HP 6.5.1]
  - provide a list of all those external to the entity who have access to individually identified health care information and the purposes for which they are given such access [HP 6.5.2]
- mechanism to determine how enrollees access their health care information and petition to correct erroneous information [HP 6.5.4]

**TAB I: Professional Provider Application & Credentialing**

- each application shall be reviewed by the health plan’s credentialing body [HP 5.7.1]
- criteria are based on input from the professional providers credentialed in the health plan [HP 5.7.2 a)]
- criteria are available to applicants [HP 5.7.2 b)]
- professional provider credentialing criteria must include a review of the following [HP 5.7.2 c)]:
  - current valid license/registration/certificate required to operate in RI or any other state [HP 5.7.2 c) i)]
  - history relative to any revocation, suspension, probationary status or other disciplinary action regarding a license/registration/certificate required to operate in RI or any other state [HP 5.7.2 c) ii)]
  - clinical privileges in good standing at a hospital, if applicable [HP 5.7.2 c) iii)]
  - valid DEA/Controlled Substance certificate/registration, if applicable [HP 5.7.2 c) iv)]
  - education and training consistent with the provision of services [HP 5.7.2 c) v)]
  - evidence of current board certification if provider states s/he is board certified [HP 5.7.2 c) vi)]
  - evidence of malpractice/professional liability insurance [HP 5.7.2 c) vii)]
  - history of professional liability claims resulting in settlements and/or judgments paid to the claimant [HP 5.7.2 c) viii)]
- if applicable, address economic profiling in accordance with sections 5.7.3 and 5.7.4 [HP 5.7.3; HP 5.7.4]
- the health plan shall take action concerning a professional provider’s application within 180 days of receipt of application [HP 5.10]
- if the health plan denies a professional provider, the provider shall receive written notification of all reasons for denial within 60 days of receipt of a completed and verified application [HP 5.11]
- due process for credential professional providers for all adverse decisions resulting in a change of contractual privileges of a credentialed professional provider [HP 5.12]
- any changes to a physician’s contract by a health plan shall include, but not be limited to, effects upon utilization review and management activities or payment or coverage policies. [HP 5.13]
  - These changes shall include an explanation of the contractual changes in non-technical terms and must be sent to the physician in writing by mail [HP 5.13.1]
- a physician shall have an opportunity to amend or terminate the contract as a result of the proposed changes within 60 calendar days of receipt of the notice of change [HP 5.14]
- any decision to terminate a contract by a physician shall be effective 15 calendar days from the mailing of the termination notice and such notice must be made in writing by mail to the health plan [HP 5.14.1]

**TAB J: Input into Plan Policies & Procedures**

- formal mechanism that allows providers to provide input into written policies of the health plan including: technology; medications; procedures; utilization review criteria; quality criteria; credentialing criteria; and medical/health care management procedures [HP 6.7]
- a mechanism that allows subscribers to provide periodic input into the health plan's procedures & processes regarding the delivery of health care services [HP 6.8]

## IV. CONTRACT ELEMENTS

### TAB K: Contract Elements

- Current copies of all provider and professional provider contracts/agreements that are used by the health plan
  - all provider contracts must address the following requirements:
    - [HMO only] a statement that no enrollee shall be liable to any provider for charges for covered health services, except for amounts due for co-payments, when provided or made available during a period in which premiums were paid by or on behalf of the enrollee [HP 5.2]
    - a health plan shall not include a most favored rate clause [HP 5.15]
    - a health plan shall not include clauses that allow for the health plan to terminate the contract "without cause" [HP 5.3]
  - due process offered to credentialed professional providers for all adverse decisions resulting in a change of contractual privileges of a credentialed professional provider shall include statements that address the following requirements [HP 5.12]:
    - professional provider shall be notified in writing of the proposed action and the reasons for the proposed actions [HP 5.12.1 a) i) and ii)]
    - the professional provider shall be given the opportunity to appeal the proposed action [HP 5.12.1 a) iii)]
    - the appeal, if requested, shall be completed prior to implementation of the proposed actions [HP 5.12.1 a) iv)]
    - the health plan shall maintain an internal appeals process, for professional providers which has reasonable time limits for the resolution of the internal appeals [HP 5.12.1 a) v)]
    - professional providers shall not be required to waive their rights to appeal as a condition of their contract [HP 5.12 b) i)]
    - when a health plan has reason to suspect there is immediate danger to a patient, it shall notify the Director of Health immediately and shall take the appropriate action to protect its enrollees [HP 5.12.1 c)]
  - all physician contracts must include the following requirements:
    - termination of a physician's contract will not affect the method of payment or reduce the amount of reimbursement to the physician by the health plan for any patient in active treatment for an acute medical condition at the time the patient's physician terminates the contract with the health plan until the active treatment is concluded or, if earlier, one year after the termination [HP 5.14.2]
      - during the active treatment period, the physician will be subject to all the terms and conditions of the terminated physician contract including, but not limited to, all reimbursement provisions which limit the patient's liability [HP 5.14.2 a)]