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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2013

A N A C T

RELATING TO HEALTH AND SAFETY - THE RHODE ISLAND HEALTH CARE REFORM ACT OF 2013

Introduced By: Representatives Keable, Tanzi, Blazejewski, and Silva

Date Introduced: June 26, 2013

Referred To: House Corporations

It is enacted by the General Assembly as follows:

SECTION 1. Legislative findings. The general assembly declares that:

(1) It is the intention of the Rhode Island general assembly to achieve the goal of access to high quality health care at an affordable cost;

(2) Transparency is key in achieving an accountable and competitive health care system with increased consumer confidence;

(3) Attraction, retention and training of a diverse workforce is critically important to the evolution of health care service delivery;

(4) Rhode Islanders would benefit from instituting healthcare reforms that are tied to patient centered care and values based outcomes; and

(5) This act aims to build upon existing efforts in the state among health plans, providers and state entities to reduce costs, improve transparency and enhance investments in the Rhode Island healthcare system while providing opportunities for innovation in the delivery of healthcare services.

SECTION 2. Section 23-17-10.2 of the General Laws in Chapter 23-17 entitled "Licensing of Health Care Facilities" is hereby amended to read as follows:

23-17-10.2. Full financial disclosure by hospitals. -- Any hospital licensed under this chapter, other than state-operated hospitals, shall annually submit to the director of ~~business regulation~~ the department of health:

(a) ~~public~~ Public audited financial statements containing information concerning all hospital-related corporations, holding corporations and subsidiary corporations, whether for-profit or not-for-profit. Any hospital corporation, holding corporation, or subsidiary corporation, whether for-profit or not-for-profit, which is not audited by an independent public auditor due to limited activity or small size, shall submit a financial statement certified by the chief executive officer of that corporation. ~~All information provided shall be available to the public for inspection.~~

(b) Any hospitals licensed under this chapter, other than state operated hospitals shall on or before January 1, 2014 and annually thereafter, submit a summary of financial information in accordance with the following: (1) Not-for-profit hospitals shall submit a summary of the information contained in section 501(c), 527, or 4947(a)(1) of the internal revenue code 990 form including:

(i) Its statement of financial position;

(ii) The verified total costs incurred by the hospital in providing health services;

(iii) Total payroll including fringe benefits, and any other remuneration of the top five (5) highest compensated employees and/or contractors, identified by position description and specialty;

(iv) The verified net costs of medical education; and

(v) Administrative expenses; as defined by the director of the department of health.

(2) For-profit hospitals shall submit the information listed in (b)(1) of this section in a form approved by the department of health.

(c) All information provided shall be made available to the healthcare planning and accountability advisory council, as established in section 23-81-4 and shall be made available to the public for inspection.

SECTION 3. Section 23-17-40 of the General Laws in Chapter 23-17 entitled "Licensing of Health Care Facilities" is hereby amended to read as follows:

23-17-40. Hospital events reporting. -- (a) Definitions. As used in this section, the following terms shall have the following meanings:

(1) "Adverse event" means injury to a patient resulting from a medical intervention, and not to the underlying condition of the patient.

(2) "Checklist of care" means predetermined steps to be followed by a team of healthcare providers before, during or after a given procedure to decrease the possibility of adverse effects and other patient harm by articulating standards of care.

(b) Reportable events as defined in subsection ~~(b)~~(c) shall be reported to the department

of health division of facilities regulation on a telephone number maintained for that purpose. Hospitals shall report incidents as defined in subsection ~~(b)~~(c) within twenty-four (24) hours of when the accident occurred or if later, within twenty-four (24) hours of receipt of information causing the hospital to believe that a reportable event has occurred.

~~(b)~~(c) ~~(1)~~ Reportable events are defined as follows:

~~(i)~~(1) Fires or internal disasters in the facility which disrupt the provisions of patient care services or cause harm to patients or personnel;

~~(ii)~~(2) Poisoning involving patients of the facility;

~~(iii)~~(3) Infection outbreaks as defined by the department in regulation;

~~(iv)~~(4) Kidnapping and inpatient psychiatric elopements and elopements by minors;

~~(v)~~(5) Strikes by personnel;

~~(vi)~~(6) Disasters or other emergency situations external to the hospital environment which adversely affect facility operations; and

~~(vii)~~(7) Unscheduled termination of any services vital to the continued safe operation of the facility or to the health and safety of its patients and personnel.

~~(2)~~(d) Any hospital filing a report with the attorney general's office concerning abuse, neglect and mistreatment of patients as defined in chapter 17.8 of this title shall forward a copy of the report to the department of health. In addition, a copy of all hospital notifications and reports made in compliance with the federal Safe Medical Devices Act of 1990, 21 U.S.C. section 301 et seq., shall be forwarded to the department of health within the time specified in the federal law.

~~(c)~~(e) Any reportable incident in a hospital that results in patient injury as defined in subsection ~~(d)~~(f) shall be reported to the department of health with seventy-two (72) hours or when the hospital has reasonable cause to believe that an incident as defined in subsection ~~(d)~~ (f) has occurred. The department of health shall promulgate rules and regulations to include the process whereby health care professionals with knowledge of an incident shall report it to the hospital, requirements for the hospital to conduct a root cause analysis of the incident or other appropriate process for incident investigation and to develop and file a performance improvement plan, and additional incidents to be reported that are in addition to those listed in subsection ~~(d)~~(f). In its reports, no personal identifiers shall be included. The hospital shall require the appropriate committee within the hospital to carry out a peer review process to determine whether the incident was within the normal range of outcomes, given the patient's condition. The hospital shall notify the department of the outcome of the internal review, and if the findings determine that the incident was within the normal range of patient outcomes no further action is required. If the findings conclude that the incident was not within the normal range of patient outcomes, the

hospital shall conduct a root cause analysis or other appropriate process for incident investigation to identify causal factors that may have lead to the incident and develop a performance improvement plan to prevent similar incidents from occurring in the future. The hospital shall also provide to the department of health the following information:

(1) An explanation of the circumstances surrounding the incident;

(2) An updated assessment of the effect of the incident on the patient;

(3) A summary of current patient status including follow-up care provided and post-incident diagnosis; ~~and~~

(4) A summary of all actions taken to correct identified problems to prevent recurrence of the incident and/or to improve overall patient care and to comply with other requirements of this section.

~~(d)~~(f) Incidents to be reported are those causing or involving:

(1) Brain injury;

(2) Mental impairment;

(3) Paraplegia;

(4) Quadriplegia;

(5) Any type of paralysis;

(6) Loss of use of limb or organ;

(7) Hospital stay extended due to serious or unforeseen complications;

(8) Birth injury;

(9) Impairment of sight or hearing;

(10) Surgery on the wrong patient;

(11) Subjecting a patient to a procedure other than that ordered or intended by the patient's attending physician;

(12) Any other incident that is reported to their malpractice insurance carrier or self-insurance program;

(13) Suicide of a patient during treatment or within five (5) days of discharge from an inpatient or outpatient unit (if known);

(14) Blood transfusion error; and

(15) Any serious or unforeseen complication, that is not expected or probable, resulting in an extended hospital stay or death of the patient.

~~(e)~~(g) This section does not replace other reporting required by this chapter.

~~(f)~~(h) Nothing in this section shall prohibit the department from investigating any event or incident.

~~(g)~~(i) All reports to the department under this section shall be subject to the provisions of section 23-17-15. In addition, all reports under this section, together with the peer review records and proceedings related to events and incidents so reported and the participants in the proceedings shall be deemed entitled to all the privileges and immunities for peer review records set forth in section 23-17-25.

~~(h)~~(j) The department shall issue an annual report by March 31 each year providing aggregate summary information on the events and incidents reported by hospitals as required by this chapter. A copy of the report shall be forwarded to the governor, the speaker of the house, the senate president and members of the health care quality steering committee established pursuant to section 23-17.17-6.

~~(i)~~(k) The director shall review the list of incidents to be reported in subsection ~~(d)~~(f) above at least biennially to ascertain whether any additions, deletions or modifications to the list are necessary. In conducting the review, the director shall take into account those adverse events identified on the National Quality Forum's List of Serious Reportable Events. In the event the director determines that incidents should be added, deleted or modified, the director shall make such recommendations for changes to the legislature.

SECTION 4. Section 23-81-4 of the General Laws in Chapter 23-81 entitled "Rhode Island Coordinated Health Planning Act of 2006" is hereby amended to read as follows:

23-81-4. Powers of the health care planning and accountability advisory council. -- Powers of the council shall include, but not be limited to the following:

(a) The authority to develop and promote studies, advisory opinions and to recommend a unified health plan on the state's health care delivery and financing system, including but not limited to:

(1) Ongoing assessments of the state's health care needs and health care system capacity that are used to determine the most appropriate capacity of and allocation of health care providers, services, including transportation services, and equipment and other resources, to meet Rhode Island's health care needs efficiently and affordably. These assessments shall be used to advise the "determination of need for new health care equipment and new institutional health services" or "certificate of need" process through the health services council;

(2) The establishment of Rhode Island's long range health care goals and values, and the recommendation of innovative models of health care delivery, that should be encouraged in Rhode Island;

(3) Health care payment models that reward improved health outcomes;

(4) Measurements of quality and appropriate use of health care services that are designed

to evaluate the impact of the health planning process;

(5) Plans for promoting the appropriate role of technology in improving the availability of health information across the health care system, while promoting practices that ensure the confidentiality and security of health records; and

(6) Recommendations of legislation and other actions that achieve accountability and adherence in the health care community to the council's plans and recommendations.

(b) Convene meetings of the council no less than every sixty (60) days, which shall be subject to the open meetings laws and public records laws of the state, and shall include a process for the public to place items on the council's agenda.

(c) Appoint advisory committees as needed for technical assistance throughout the process.

(d) Modify recommendations in order to reflect changing health care systems needs.

(e) Promote responsiveness to recommendations among all state agencies that provide health service programs, not limited to the five (5) state agencies coordinated by the executive office of the health and human services.

(f) Coordinate the review of existing data sources from state agencies and the private sector that are useful to developing a unified health plan.

(g) Formulating, testing, and selecting policies and standards that will achieve desired objectives.

(h) In consultation with the office of the health insurance commissioner, the council shall review health system total cost drivers and provide findings, and, if appropriate related recommendations to the governor and general assembly on or before July 1, 2014.

(i) Coordinate a comprehensive review of mental health and substance abuse incidence rates, service use rates, capacity and potentially high and rising spending.

(j) Examine the volume and spending trends for pediatric inpatient and outpatient services, including the evolving role of intensive care units (ICUs).

(k) Subject to available resources and time, in consultation with the department of health, provide periodic assessments beginning on or before October 1, 2014, to the general assembly on the appropriate mix of Rhode Island's primary care workforce. The assessments shall include analyses of current and future primary care professional supply and demand, recruitment, scope of practice and licensure, workforce training issues, and potential incentives with recommendations to enhance the supply and diversity of the primary care workforce.

~~(h)~~(l) Provide an annual report each July, after the convening of the council, to the governor and general assembly on implementation of the plan adopted by the council. This

annual report shall:

(1) Present the strategic recommendations, updated annually;

(2) Assess the implementation of strategic recommendations in the health care market;

(3) Compare and analyze the difference between the guidance and the reality;

(4) Recommend to the governor and general assembly legislative or regulatory revisions necessary to achieve the long-term goals and values adopted by the council as part of its strategic recommendations, and assess the powers needed by the council or governmental entities of the state deemed necessary and appropriate to carry out the responsibilities of the council. ~~The initial priority of the council shall be an assessment of the needs of the state with regard to hospital services and to present recommendations, if any, for modifications to the Hospital Conversion Act and the Certificate of Need Program to execute the strategic recommendations of the council. The council shall provide an initial report and recommendations to the governor and general assembly on or before March 1, 2013.~~

(5) Include the request for a hearing before the appropriate committees of the general assembly.

(6) Include a response letter from each state agency that is affected by the state health plan describing the actions taken and planned to implement the plans recommendations.

SECTION 5. Chapter 27-69 of the General Laws entitled "Mandated Benefits" is hereby amended by adding thereto the following section:

27-69-7. Mandated benefit statement of intent. – Notwithstanding any general law enacted after January 1, 2014, any legislation that would create a new state health benefit mandate, or expand upon an existing health benefit, shall contain a statement of intent that clearly provides the purpose and objectives of the health benefit mandate, including measurable goals expected to be achieved by the new or expanded benefit mandate. These goals should address both commercial insurance affordability and population health outcomes.

SECTION 6. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended to read as follows:

42-14.5-3. Powers and duties. [Contingent effective date; see effective dates under this section.] -- The health insurance commissioner shall have the following powers and duties:

(a) To conduct quarterly public meetings throughout the state, separate and distinct from rate hearings pursuant to section 42-62-13, regarding the rates, services and operations of insurers licensed to provide health insurance in the state the effects of such rates, services and operations on consumers, medical care providers, patients, and the market environment in which such

insurers operate and efforts to bring new health insurers into the Rhode Island market. Notice of not less than ten (10) days of said hearing(s) shall go to the general assembly, the governor, the Rhode Island Medical Society, the Hospital Association of Rhode Island, the director of health, the attorney general and the chambers of commerce. Public notice shall be posted on the department's web site and given in the newspaper of general circulation, and to any entity in writing requesting notice.

(b) To make recommendations to the governor and the house of representatives and senate finance committees regarding health care insurance and the regulations, rates, services, administrative expenses, reserve requirements, and operations of insurers providing health insurance in the state, and to prepare or comment on, upon the request of the governor, or chairpersons of the house or senate finance committees, draft legislation to improve the regulation of health insurance. In making such recommendations, the commissioner shall recognize that it is the intent of the legislature that the maximum disclosure be provided regarding the reasonableness of individual administrative expenditures as well as total administrative costs. The commissioner shall ~~also~~ make recommendations on the levels of reserves including consideration of: targeted reserve levels; trends in the increase or decrease of reserve levels; and insurer plans for distributing excess reserves.

(c) To establish a consumer/business/labor/medical advisory council to obtain information and present concerns of consumers, business and medical providers affected by health insurance decisions. The council shall develop proposals to allow the market for small business health insurance to be affordable and fairer. The council shall be involved in the planning and conduct of the quarterly public meetings in accordance with subsection (a) above. The advisory council shall develop measures to inform small businesses of an insurance complaint process to ensure that small businesses that experience rate increases in a given year may request and receive a formal review by the department. The advisory council shall assess views of the health provider community relative to insurance rates of reimbursement, billing and reimbursement procedures, and the insurers' role in promoting efficient and high quality health care. The advisory council shall issue an annual report of findings and recommendations to the governor and the general assembly and present their findings at hearings before the house and senate finance committees. The advisory council is to be diverse in interests and shall include representatives of community consumer organizations; small businesses, other than those involved in the sale of insurance products; and hospital, medical, and other health provider organizations. Such representatives shall be nominated by their respective organizations. The advisory council shall be co-chaired by the health insurance commissioner and a community

consumer organization or small business member to be elected by the full advisory council.

(d) To establish and provide guidance and assistance to a subcommittee ("The Professional Provider-Health Plan Work Group") of the advisory council created pursuant to subsection (c) above, composed of health care providers and Rhode Island licensed health plans. This subcommittee shall include in its annual report and presentation before the house and senate finance committees the following information:

~~(i)~~(1) A method whereby health plans shall disclose to contracted providers the fee schedules used to provide payment to those providers for services rendered to covered patients;

~~(ii)~~(2) A standardized provider application and credentials verification process, for the purpose of verifying professional qualifications of participating health care providers;

~~(iii)~~(3) The uniform health plan claim form utilized by participating providers;

~~(iv)~~(4) Methods for health maintenance organizations as defined by section 27-41-1, and nonprofit hospital or medical service corporations as defined by chapters 27-19 and 27-20, to make facility-specific data and other medical service-specific data available in reasonably consistent formats to patients regarding quality and costs. This information would help consumers make informed choices regarding the facilities and/or clinicians or physician practices at which to seek care. Among the items considered would be the unique health services and other public goods provided by facilities and/or clinicians or physician practices in establishing the most appropriate cost comparisons~~.~~;

~~(v)~~(5) All activities related to contractual disclosure to participating providers of the mechanisms for resolving health plan/provider disputes; ~~and~~

~~(vi)~~(6) The uniform process being utilized for confirming in real time patient insurance enrollment status, benefits coverage, including co-pays and deductibles~~.~~;

~~(vii)~~(7) Information related to temporary credentialing of providers seeking to participate in the plan's network and the impact of said activity on health plan accreditation;

~~(viii)~~(8) The feasibility of regular contract renegotiations between plans and the providers in their networks~~.~~; and

~~(ix)~~(9) Efforts conducted related to reviewing impact of silent PPOs on physician practices.

(e) To enforce the provisions of Title 27 and Title 42 as set forth in section 42-14-5(d).

(f) To provide analysis of the Rhode Island Affordable Health Plan Reinsurance Fund. The fund shall be used to effectuate the provisions of sections 27-18.5-8 and 27-50-17.

(g) To analyze the impact of changing the rating guidelines and/or merging the individual health insurance market as defined in chapter 27-18.5 and the small employer health insurance

market as defined in chapter 27-50 in accordance with the following:

~~(i)~~(1) The analysis shall forecast the likely rate increases required to effect the changes recommended pursuant to the preceding subsection (g) in the direct pay market and small employer health insurance market over the next five (5) years, based on the current rating structure, and current products.

~~(ii)~~(2) The analysis shall include examining the impact of merging the individual and small employer markets on premiums charged to individuals and small employer groups.

~~(iii)~~(3) The analysis shall include examining the impact on rates in each of the individual and small employer health insurance markets and the number of insureds in the context of possible changes to the rating guidelines used for small employer groups, including: community rating principles; expanding small employer rate bonds beyond the current range; increasing the employer group size in the small group market; and/or adding rating factors for broker and/or tobacco use.

~~(iv)~~(4) The analysis shall include examining the adequacy of current statutory and regulatory oversight of the rating process and factors employed by the participants in the proposed new merged market.

~~(v)~~(5) The analysis shall include assessment of possible reinsurance mechanisms and/or federal high-risk pool structures and funding to support the health insurance market in Rhode Island by reducing the risk of adverse selection and the incremental insurance premiums charged for this risk, and/or by making health insurance affordable for a selected at-risk population.

~~(vi)~~(6) The health insurance commissioner shall work with an insurance market merger task force to assist with the analysis. The task force shall be chaired by the health insurance commissioner and shall include, but not be limited to, representatives of the general assembly, the business community, small employer carriers as defined in section 27-50-3, carriers offering coverage in the individual market in Rhode Island, health insurance brokers and members of the general public.

~~(vii)~~(7) For the purposes of conducting this analysis, the commissioner may contract with an outside organization with expertise in fiscal analysis of the private insurance market. In conducting its study, the organization shall, to the extent possible, obtain and use actual health plan data. Said data shall be subject to state and federal laws and regulations governing confidentiality of health care and proprietary information.

~~(viii)~~(8) The task force shall meet as necessary and include their findings in the annual report and the commissioner shall include the information in the annual presentation before the house and senate finance committees.

(h) To establish and convene a workgroup representing health care providers and health insurers for the purpose of coordinating the development of processes, guidelines, and standards to streamline health care administration that are to be adopted by payors and providers of health care services operating in the state. This workgroup shall include representatives with expertise that would contribute to the streamlining of health care administration and that are selected from hospitals, physician practices, community behavioral health organizations, each health insurer and other affected entities. The workgroup shall also include at least one designee each from the Rhode Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the Rhode Island Health Center Association, and the Hospital Association of Rhode Island. The workgroup shall consider and make recommendations for:

(1) Establishing a consistent standard for electronic eligibility and coverage verification. Such standard shall:

(i) Include standards for eligibility inquiry and response and, wherever possible, be consistent with the standards adopted by nationally recognized organizations, such as the centers for Medicare and Medicaid services;

(ii) Enable providers and payors to exchange eligibility requests and responses on a system-to-system basis or using a payor supported web browser;

(iii) Provide reasonably detailed information on a consumer's eligibility for health care coverage, scope of benefits, limitations and exclusions provided under that coverage, cost-sharing requirements for specific services at the specific time of the inquiry, current deductible amounts, accumulated or limited benefits, out-of-pocket maximums, any maximum policy amounts, and other information required for the provider to collect the patient's portion of the bill;

(iv) Reflect the necessary limitations imposed on payors by the originator of the eligibility and benefits information;

(v) Recommend a standard or common process to protect all providers from the costs of services to patients who are ineligible for insurance coverage in circumstances where a payor provides eligibility verification based on best information available to the payor at the date of the request of eligibility.

(2) Developing implementation guidelines and promoting adoption of such guidelines for:

(i) The use of the national correct coding initiative code edit policy by payors and providers in the state;

(ii) Publishing any variations from codes and mutually exclusive codes by payors in a manner that makes for simple retrieval and implementation by providers;

(iii) Use of health insurance portability and accountability act standard group codes, reason codes, and remark codes by payors in electronic remittances sent to providers;

(iv) The processing of corrections to claims by providers and payors.

(v) A standard payor denial review process for providers when they request a reconsideration of a denial of a claim that results from differences in clinical edits where no single, common standards body or process exists and multiple conflicting sources are in use by payors and providers.

(vi) Nothing in this section or in the guidelines developed shall inhibit an individual payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of detecting and deterring fraudulent billing activities. The guidelines shall require that each payor disclose to the provider its adjudication decision on a claim that was denied or adjusted based on the application of such edits and that the provider have access to the payor's review and appeal process to challenge the payor's adjudication decision.

(vii) Nothing in this subsection shall be construed to modify the rights or obligations of payors or providers with respect to procedures relating to the investigation, reporting, appeal, or prosecution under applicable law of potentially fraudulent billing activities.

(3) Developing and promoting widespread adoption by payors and providers of guidelines to:

(i) Ensure payors do not automatically deny claims for services when extenuating circumstances make it impossible for the provider to obtain a preauthorization before services are performed or notify a payor within an appropriate standardized timeline of a patient's admission;

(ii) Require payors to use common and consistent processes and time frames when responding to provider requests for medical management approvals. Whenever possible, such time frames shall be consistent with those established by leading national organizations and be based upon the acuity of the patient's need for care or treatment. For the purposes of this section, medical management includes prior authorization of services, preauthorization of services, precertification of services, post service review, medical necessity review, and benefits advisory;

(iii) Develop, maintain, and promote widespread adoption of a single common website where providers can obtain payors' preauthorization, benefits advisory, and preadmission requirements; and

(iv) Establish guidelines for payors to develop and maintain a website that providers can use to request a preauthorization, including a prospective clinical necessity review; receive an authorization number; and transmit an admission notification.

(j) To monitor the adequacy of each health plan's compliance with the provisions of the

federal mental health parity act, including a review of related claims processing and reimbursement procedures. Findings, recommendations and assessments shall be made available to the public.

(k) To monitor the transition from fee for service and toward global and other alternative payment methodologies for the payment for healthcare services. Alternative payment methodologies should be assessed for their likelihood to promote access to affordable health insurance, health outcomes and performance.

(l) To report annually, no later than July 1, 2014, then biannually thereafter, on hospital payment variation, including findings and recommendations, subject to available resources.

(m) Notwithstanding any provision of the general or public laws or regulation to the contrary, provide a report with findings and recommendations to the president of the senate and the speaker of the house, on or before April 1, 2014, including, but not limited to, the following information:

(1) The impact of the current mandated healthcare benefits as defined in sections 27-18-48.1, 27-18-60, 27-18-62, 27-18-64, similar provisions in title 27, chapters 19, 20 and 41, and subsection 27-18-3(c), 27-38.2-1 et seq., or others as determined by the commissioner, on the cost of health insurance for fully insured employers, subject to available resources;

(2) Current provider and insurer mandates that are unnecessary and/or duplicative due to the existing standards of care and/or delivery of services in the healthcare system;

(3) A state-by-state comparison of health insurance mandates and the extent to which Rhode Island mandates exceed other states benefits; and

(4) Recommendations for amendments to existing mandated benefits based on the findings in (1), (2) and (3) above.

(n) On or before July 1, 2014, the office of the health insurance commissioner in collaboration with the director of health and lieutenant governor's office shall submit a report to the general assembly and the governor to inform the design of accountable care organizations (ACOs) in Rhode Island as unique structures for comprehensive healthcare delivery and value based payment arrangements, that shall include, but not limited to:

(1) Utilization review;

(2) Contracting; and

(3) Licensing and regulation.

SECTION 7. Section 42-14.6-4 of the General Laws in Chapter 42-14.6 entitled "Rhode Island All-Payer Patient-Centered Medical Home Act" is hereby amended to read as follows:

42-14.6-4. Promotion of the patient-centered medical home. -- (a) Care coordination

payments.

(1) The commissioner and the secretary shall convene a patient-centered medical home collaborative consisting of the entities described in subdivision 42-14.6-3(7). The commissioner shall require participation in the collaborative by all of the health insurers described above. The collaborative shall propose, by January 1, 2012, a payment system, to be adopted in whole or in part by the commissioner and the secretary, that requires all health insurers to make per-person care coordination payments to patient-centered medical homes, for providing care coordination services and directly managing on-site or employing care coordinators as part of all health insurance plans offered in Rhode Island. The collaborative shall provide guidance to the state health care program as to the appropriate payment system for the state health care program to the same patient-centered medical homes; the state health care program must justify the reasons for any departure from this guidance to the collaborative.

(2) The care coordination payments under this shall be consistent across insurers and patient-centered medical homes and shall be in addition to any other incentive payments such as quality incentive payments. In developing the criteria for care coordination payments, the commissioner shall consider the feasibility of including the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care. The commissioner may direct the collaborative to determine a schedule for phasing in care coordination fees.

(3) The care coordination payment system shall be in place through July 1, 2016. Its continuation beyond that point shall depend on results of the evaluation reports filed pursuant to section 42-14.6-6.

(4) Examination of other payment reforms. - By January 1, 2013, the commissioner and the secretary shall direct the collaborative to consider additional payment reforms to be implemented to support patient-centered medical homes including, but not limited to, payment structures (to medical home or other providers) that:

(i) Reward high-quality, low-cost providers;

(ii) Create enrollee incentives to receive care from high-quality, low-cost providers;

(iii) Foster collaboration among providers to reduce cost shifting from one part of the health continuum to another; and

(iv) Create incentives that health care be provided in the least restrictive, most appropriate setting.

(5) The patient-centered medical home collaborative shall examine and make recommendations to the secretary regarding the designation of patient-centered medical homes, in

order to promote diversity in the size of practices designated, geographic locations of practices designated and accessibility of the population throughout the state to patient-centered medical homes.

(b) The patient-centered medical home collaborative shall propose to the secretary for adoption, ~~the~~ standards for the patient-centered medical home to be used in the payment system~~,~~ ~~based on national models where feasible~~. In developing these standards, the existing standards by the national committee for quality assurance, or other independent accrediting organizations may be considered where feasible.

SECTION 8. Chapter 42-14.6 of the General Laws entitled "Rhode Island All-Payer Patient-Centered Medical Home Act" is hereby amended by adding thereto the following section:

42-14.6-9. State patient-centered medical home program expansion. -- (a) The director of the department of administration is hereby authorized to expand the current patient-centered medical home program for state employees and retirees with chronic health conditions that are covered by the state employees health benefit program and are high frequency healthcare utilizers. This program shall be in addition to and shall not alter the Rhode Island All-Payer Patient-Centered Medical Home Act as set forth in section 42-14.6-4.

(b) For the purposes of this program, "high utilizers" means individuals who are among the top one to five percent (1-5%) of utilization within their payer group.

(c) "Patient-centered medical home" means a practice that satisfies the characteristics described in section 42-14.6-2.

SECTION 9. 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 - THE RHODE ISLAND HEALTH CARE REFORM ACT OF 2013

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This act would make a number of substantive and definitional changes to various provisions of the general laws governing the healthcare system.

This act would take effect upon passage.

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