2011 -- S 770 SUBSTITUTE A AS AMENDED

=======
LC02313/SUB A
=======

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. 2011

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT

Introduced By: Senator Elizabeth A. Crowley

Date Introduced: March 24, 2011

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Title 42 of the General Laws entitled "STATE AFFAIRS AND GOVERNMENT" is hereby amended by adding thereto the following chapter:

CHAPTER 14.6

RHODE ISLAND ALL-PAYER PATIENT-CENTERED MEDICAL HOME ACT

42-14.6-1. Short title. – This chapter shall be known and may be cited as the "Rhode Island All-Payer Patient-Centered Medical Home Act."

42-14.6-2. Legislative purpose and intent. – (a) The general assembly recognizes that patient-centered medical home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The patient-centered medical home is a health care setting that facilitates partnerships between individual patients, and their personal physicians, physician assistants and advanced practice nurses, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. The goals of the patient-centered medical home are improved delivery of comprehensive primary care and focus on better outcomes for patients, more efficient payment to physicians and other clinicians and better value, accountability and transparency to purchasers and consumers. The patient-centered medical home changes the interaction between patients and physicians and other clinicians from a series of episodic office visits to an ongoing two-way relationship. The patient-centered medical home helps medical care

providers work to keep patients healthy instead of just healing them when they are sick. In the patient-centered medical home patients are active participants in managing their health with a shared goal of staying as healthy as possible.

(b) The patient-centered medical home has the following characteristics:

(1) Emphasizes, enhances, and encourages the use of primary care;

(2) Focuses on delivering high quality, efficient, and effective health care services;

(3) Encourages patient-centered care, including active participation by the patient and family, or designated agent for health care decision-making, as appropriate in decision-making and care plan development, and providing care that is appropriate to the patient's individual needs and circumstances;

(4) Provides patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition;

(5) Enables and encourages utilization of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;

(6) Focuses initially on patients who have or are at risk of developing chronic health conditions;

(7) Incorporates measures of quality, resource use, cost of care, and patient experience;

(8) Ensures the use of health information technology and systematic follow-up, including the use of patient registries; and

(9) Encourages the use of evidence-based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(c) The general assembly recognizes that Rhode Island is a national leader in all-payer patient-centered medical homes through a model developed by providers and financed through the voluntary participation of insurers. The continuation of this model, developed by the Rhode Island chronic care sustainability initiative, is recognized as critical to the future structure of the Rhode Island primary care delivery system. The general assembly also recognizes that the model created through this legislation is not the only model for patient-centered medical homes and in no way seeks to limit the innovation of providers and insurers in the future.

42-14.6-3. Definitions. – As used in this section, the following terms shall have the following meanings:

(1) "Commissioner" means the health insurance commissioner.

(2) "Health insurer" means all entities licensed, or required to be licensed, in this state

that offer health benefit plans in Rhode Island including, but not limited to, nonprofit hospital service corporations and nonprofit medical service corporations established pursuant to chapters 27-19 and 27-20, and health maintenance organizations established pursuant to chapter 27-41 or as defined in chapter 42-62, a fraternal benefit society or any other entity subject to state insurance regulation that provides medical care on the basis of a periodic premium, paid directly or through an association, trust or other intermediary, and issued, renewed, or delivered within or without Rhode Island.

(3) “Health insurance plan” means any individual, general, blanket or group policy of health, accident and sickness insurance issued by a health insurer (as herein defined). Health Insurance Plan shall not include insurance coverage providing benefits for:

(i) Hospital confinement indemnity;

(ii) Disability income;

(iii) Accident only;

(iv) Long-term care;

(v) Medicare supplement;

(vi) Limited benefit health;

(vii) Specified disease indemnity;

(viii) Sickness or bodily injury or death by accident or both; and

(ix) Other limited benefit policies.

(4) "Personal clinician" means a physician, physician assistant, or an advanced practice nurse licensed by the department of health.

(5) "State health care program" means medical assistance, RIteCare, and any other health insurance program provided through the office of health and human services (OHHS) and its component state agencies state health care program does not include any health insurance plan provided as a benefit to state employees or retirees.

(6) “Patient-centered medical home” means a practice that satisfies the characteristics described in section 42-14.6-2, and is designated as such by the secretary or through alternative models as provided for in section 42-14.6-7, based on standards recommended by the patient-centered medical home collaborative.

(7) “Patient-centered medical home collaborative” means a community advisory council, including, but not limited to, participants in the existing Rhode Island patient-centered medical home pilot project, and health insurers, physicians and other clinicians, employers, the state health care program, relevant state agencies, community health centers, hospitals, other providers, patients, and patient advocates which shall provide consultation and recommendations to the

secretary and the commissioner on all matters relating to proposed regulations, development of standards, and development of payment mechanisms.

(8) "Secretary" means the secretary of the executive office of health and human services.

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.

42-14.6-5. Annual reports on implementation and administration. – The secretary and commissioner shall report annually to the legislature on the implementation and administration of the patient-centered medical home model.

42-14.6-6. Evaluation reports. – (a) The secretary and commissioner shall provide to the legislature comprehensive evaluations of the patient-centered medical home model two (2) years and four (4) years after implementation. The evaluation must include:

(1) The number of enrollees in patient-centered medical homes in the collaborative and the health characteristics of enrollees;

(2) The number and geographic distribution of patient-centered medical home providers in the collaborative and the number of primary care physicians per thousand populations;

(3) The performance and quality of care of patient-centered medical homes in the collaborative;

(4) The estimated impact of patient-centered medical homes on access to preventive care;

(5) Patient-centered medical home payment arrangements, and costs related to implementation and payment of care coordination fees;

(6) The estimated impact of patient-centered medical homes on health status and health disparities; and

(7) Estimated savings from implementation of the patient-centered medical home model.

(b) Health insurers shall provide to the commissioner and secretary utilization, quality, financial, and other reports, specified by the commissioner and secretary, regarding the implementation and impact of patient-centered medical homes

42-14.6-7. Alternative models. – Nothing in this section shall preclude the development of alternative patient centered medical home models by an insurer for its group and/or individual policies, or by the secretary, the commissioner or other state agencies or preclude insurers, the

secretary, the commissioner or other state agencies from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs, are enrolled in managed care long-term care programs, are dually eligible for Medicare and Medicaid, are in the waiting period for Medicare, or who have other primary coverage.

42-14.6-8. Regulations. – The secretary of health and human services and the health insurance commissioner shall develop regulations to implement this chapter.

SECTION 2. This act shall take effect upon passage.

=======
LC02313/SUB A
========

EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT

***

This act would provide for the implementation and development of a model patient-centered medical home program as a new approach to providing comprehensive primary health care for children, youths, and adults in this state.

This act would take effect upon passage.

=======
LC02313/SUB A
=======

2011 -- S 770 H.
SUBSTITUTE A

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT

=======
LC02313/SUB A
=======

==========
Presented by