

**2019 -- S 0577 SUBSTITUTE A**

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**STATE OF RHODE ISLAND**

**IN GENERAL ASSEMBLY**

**JANUARY SESSION, A.D. 2019**

**A N A C T**

**RELATING TO HEALTH AND SAFETY - OVERSIGHT OF RISK-BEARING PROVIDER ORGANIZATIONS**

Introduced By: Senators Sheehan, Miller, Goodwin, McCaffrey, and Satchell

Date Introduced: March 14, 2019

Referred To: Senate Health & Human Services

(OHIC)

It is enacted by the General Assembly as follows:

1 SECTION 1. Title 23 of the General Laws entitled "HEALTH AND SAFETY" is hereby  
2 amended by adding thereto the following chapter:

3 CHAPTER 17.28

4 OVERSIGHT OF RISK-BEARING PROVIDER ORGANIZATIONS

5 **23-17.28-1. Purpose.**

6 The legislature declares that:

7 (1) It is in the best interest of the public that health care provider organizations that accept  
8 financial risk for the delivery of health care services in our state meet the standards of this chapter  
9 to ensure that patient access to health care services and continuity of care are not unnecessarily  
10 interrupted; and

11 (2) It is a vital state function to establish these standards for the conduct of health care  
12 provider organizations in Rhode Island; and

13 (3) Nothing in this legislation is intended to change the obligation of providers or insurers  
14 to comply with the provisions of title 27.

15 **23-17.28-2. Definitions.**

16 As used in this chapter:

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

18 (2) "Health care risk contract" means a health care contract that holds the provider

1 organization financially responsible for a negotiated portion or all costs that exceed a  
2 predetermined health care services budget and thereby transfers insurer risk to the provider  
3 organization.

4 (3) "Health insurer" means every nonprofit medical service corporation, hospital service  
5 corporation, health maintenance organization, or other insurer offering or insuring health  
6 services; the term shall in addition include any entity defined as an insurer under § 42-62-4 and  
7 any third-party administrator when interacting with health care providers and enrollees on behalf  
8 of the insurer.

9 (4) "Provider organization" means any corporation, partnership, business trust,  
10 association, or organized group of persons in the business of health care delivery or management,  
11 whether incorporated or not, that represents one or more health care providers in contracting with  
12 health insurers for the payments of health care services. "Provider organization" shall include, but  
13 not be limited to, physician organizations, physician-hospital organizations, independent practice  
14 associations, provider networks, accountable care organizations, systems of care, and any other  
15 organization that contracts with health insurers for payment for health care services.

16 (5) "Risk-bearing provider organization" means a provider organization that has entered  
17 into a health care risk contract to manage the treatment of a group of patients. For the purposes of  
18 this chapter, Programs of All-Inclusive Care for the Elderly (PACE) shall not be considered a  
19 provider organization.

20 **23-17.28-3. Certification for provider organizations entering into health care risk**  
21 **contracts for Medicaid enrollees.**

22 (a) The commissioner shall, with the express agreement of the Medicaid program,  
23 establish a process for certifying provider organizations that intend to enter into health care risk  
24 contracts for Medicaid enrollees.

25 (b) The commissioner shall by regulation establish standards for certification, including  
26 the forms and information required to apply for certification. The standards may consider the  
27 provider organization's financial position, corporate structure, or other characteristics.

28 (c) The commissioner shall issue a finding regarding certification within sixty (60) days  
29 of the receipt of a complete request pursuant to subsection (b) of this section. If the commissioner  
30 denies the request for certification, the commissioner will state the reasons for the denial in  
31 writing, and the provider organization may reapply without prejudice.

32 **23-17.28-4. Financial solvency filing and review.**

33 (a) Review of financial solvency.

34 (1) The commissioner shall establish a process for reviewing the financial solvency of

1 risk-bearing provider organizations according to the standards established under subsection (b) of  
2 this section. The commissioner will utilize standardized forms and streamlined procedures to the  
3 extent possible in an effort to minimize the administrative burden on health insurers and risk-  
4 bearing provider organizations in order to comply with this chapter.

5 (2) The commissioner shall issue a finding regarding financial solvency within sixty (60)  
6 days of the receipt of a complete filing pursuant to subsection (c) or (d) of this section. The  
7 commissioner shall find one of the following:

8 (i) The risk-bearing provider organization meets the standards of financial solvency.

9 (ii) The risk-bearing provider organization does not meet the standards of financial  
10 solvency. Such a finding may be appealed pursuant to the administrative procedures act, chapter  
11 35 of title 42.

12 (3) Regardless of the findings pursuant to subsection (a)(2) of this section, the  
13 commissioner may include additional observations concerning the risk-bearing provider  
14 organization's financial solvency, including the identification of material risks facing the provider  
15 organization.

16 (b) The commissioner shall establish standards for evaluating financial solvency of risk-  
17 bearing provider organizations. The standards will consider all the health care risk contracts that a  
18 provider organization has entered into at the time of a financial solvency review and will be based  
19 on factors directly related to the risk-bearing provider organization's financial viability,  
20 experience managing risk, and risk mitigation strategies to cover potential losses under health  
21 care risk contracts.

22 (c) Within thirty (30) days of first executing a health care risk contract, a provider  
23 organization shall submit to the commissioner a financial report, and any other materials  
24 necessary to support the financial solvency review. The commissioner shall establish the form  
25 and content of this filing by regulation, including, but not limited to:

26 (1) Material terms of all the health care risk contracts that a provider organization has  
27 entered into at the time of a financial solvency review; and

28 (2) The provider organization's assets, liabilities, reserves, sources of working capital,  
29 and other sources of financial support.

30 Materials submitted under this subsection shall be considered confidential and privileged  
31 commercial information for the purposes of § 38-2-2(4)(B) and shall not be deemed public  
32 records. This requirement shall not apply to any risk-bearing provider organization that has  
33 submitted materials under subsection (d) of this section within the previous twelve (12) months.

34 (d) Risk-bearing provider organizations shall annually submit to the commissioner a

1 financial report, and any other materials necessary to support the financial solvency review. The  
2 commissioner shall establish the timing, form, and content of this filing by regulation, including,  
3 but not limited to:

4 (1) Material terms of all the health care risk contracts that a provider organization has  
5 entered into at the time of a financial solvency review; and

6 (2) The provider organization's assets, liabilities, reserves, sources of working capital,  
7 and other sources of financial support.

8 Materials submitted under this subsection shall be considered confidential and privileged  
9 commercial information for the purposes of § 38-2-2(4)(B) and shall not be deemed public  
10 records.

11 (e) If the commissioner has established one or more categories of risk contracts under §  
12 42-14.5-3(t), the commissioner shall establish standards and requirements for risk-bearing  
13 provider organizations that have entered into specific categories of risk contracts. The  
14 commissioner may waive all requirements for certain risk contracts or categories of risk contracts  
15 based on a determination that such contracts pose little risk to consumers.

16 **23-17.28-5. Corrective action plan.**

17 (a) If the commissioner finds that a risk-bearing provider organization does not meet the  
18 standards of financial solvency under § 23-17.28-4(a):

19 (1) The commissioner will identify specific deficiencies with respect to the standards of  
20 financial solvency that need to be addressed by the risk-bearing provider organization.

21 (2) The commissioner will notify the executive office of health and human services and  
22 any health insurers that have informed the office of the health insurance commissioner that they  
23 are holding health care risk contracts with the provider organization.

24 (3) The risk-bearing provider organization will establish a corrective action plan to  
25 address the deficiencies identified by the commissioner, submit the plan to the commissioner, and  
26 update the commissioner on the status of corrective on actions an ongoing basis as requested. The  
27 commissioner may establish standards for such corrective action plans by regulation.

28 (b) Ninety (90) days following a finding that a risk-bearing provider organization does  
29 not meet the standards of financial solvency under § 23-17.28-4(a), the risk-bearing provider  
30 organization shall demonstrate compliance with the corrective action plan under subsection (a)(3)  
31 of this section.

32 **23-17.28-6. Prohibition on contracting with certain risk-bearing provider**  
33 **organizations.**

34 (a) If the commissioner has issued a finding that a risk-bearing provider organization

1 does not meet the standards of financial solvency, the provider organization may not enter into or  
2 renew a health care risk contract without prior approval of the commissioner until such time as  
3 the commissioner issues a finding that the provider organization meets the standards of financial  
4 solvency.

5 (b) A provider organization may not enter into or renew a health care risk contract for  
6 Medicaid members if the provider organization has not been certified under § 23-17.28-3.

7 **23-17.28-7. Duty to update.**

8 Risk-bearing provider organizations that have previously submitted an annual financial  
9 report to the commissioner under § 23-17.28-4(c) shall:

10 (1) Notify the commissioner within thirty (30) days of any material changes to its  
11 financial position, including changes to health care risk contracts that increase the amount of risk  
12 borne by the provider organization, or reduces risk mitigation, such as through a reduction in stop  
13 loss insurance coverage; and

14 (2) Notify the commissioner within two (2) days should the risk-bearing organization  
15 become insolvent, or recognize it is in the process of becoming insolvent.

16 **23-17.28-8. Administrative penalties.**

17 (a) Whenever the commissioner shall have cause to believe that a violation of this section  
18 has occurred by any provider organization, the commissioner may, in accordance with the  
19 requirements of the administrative procedures act, chapter 35 of title 42:

20 (1) Levy an administrative penalty in an amount not less than one thousand dollars  
21 (\$1000) nor more than fifty thousand dollars (\$50,000);

22 (2) Order the violator to cease such actions;

23 (3) Require the provider organization to take such actions as are necessary to comply  
24 with this section, or the regulations thereunder; or

25 (4) Any combination of the above penalties.

26 (b) Any monetary penalties assessed pursuant to this section shall be deposited as general  
27 revenues.

28 SECTION 2. Section 27-20.9-1 of the General Laws in Chapter 27-20.9 entitled  
29 "Contract With Health Care Providers" is hereby amended to read as follows:

30 **27-20.9-1. Health care contracts -- Required provisions -- Definitions.**

31 (a) On and after January 1, 2008, a health insurer that contracts with a health care  
32 provider shall comply with the provisions of this chapter and shall include the provisions required  
33 by this chapter in the health care contract. A contract in existence prior to January 1, 2008, that is  
34 renewed or renews by its terms shall comply with the provisions of this chapter no later than

1 December 31, 2008.

2 (b) As used in this chapter, unless the context otherwise requires:

3 (1) "Health care contract" means a contract entered into or renewed between a health  
4 insurer and a health care provider for the delivery of health care services to others.

5 (2) "Health care provider" means a person licensed or certified in this state to practice  
6 medicine, pharmacy, chiropractic, nursing, physical therapy, podiatry, dentistry, optometry,  
7 occupational therapy, or other healing arts.

8 (3) "Health care risk contract" means a health care contract that holds the provider  
9 organization financially responsible for a negotiated portion or all of the costs that exceed a  
10 predetermined health care services budget and thereby transfers insurer risk to the provider  
11 organization.

12 ~~(3)~~(4) "Health insurer" means every nonprofit medical service corporation, hospital  
13 service corporation, health maintenance organization, or other insurer offering and/or insuring  
14 health services; the term shall in addition include any entity defined as an insurer under § 42-62-4  
15 and any third-party administrator when interacting with health care providers and enrollees on  
16 behalf of such an insurer.

17 (5) "Provider organization" means any corporation, partnership, business, trust,  
18 association, or organized group of persons in the business of health care delivery or management  
19 whether incorporated or not that represents one or more health care providers in contracting with  
20 health insurers for the payments of health care services. "Provider organization" shall include, but  
21 not be limited to, physician organizations, physician-hospital organizations, independent practice  
22 associations, provider networks, accountable care organizations, systems of care, and any other  
23 organization that contracts with health insurers for payment for health care services.

24 (6) "Risk-bearing provider organization" means a provider organization that has entered  
25 into a health care risk contract to manage the treatment of a group of patients. For the purposes of  
26 this chapter, Programs of All-Inclusive Care for the Elderly (PACE) shall not be considered a  
27 provider organization.

28 SECTION 3. Chapter 27-20.9 of the General Laws entitled "Contract With Health Care  
29 Providers" is hereby amended by adding thereto the following section:

30 **27-20.9-4. Health care risk contracts.**

31 (a) A health insurer shall submit information about each health care risk contract as  
32 directed by the health insurance commissioner in regulation. The commissioner will utilize  
33 standardized forms and streamlined procedures to the extent possible in an effort to minimize the  
34 administrative burden on health insurers and risk-bearing provider organizations in order to

1 comply with this chapter.

2 (b) A health insurer shall submit health care risk contracts and relevant related material to  
3 the commissioner within thirty (30) days of a request of such information. Such contracts shall be  
4 considered confidential and privileged commercial information for the purposes of § 38-2-2(4)(B)  
5 and shall not be deemed public records.

6 (c) A health insurer shall not enter into or renew a health care risk contract with a  
7 provider organization for which the commissioner has issued a finding that the provider  
8 organization does not meet the standards of financial solvency under § 23-17.28-4, until such  
9 time as the commissioner issues a finding that the provider organization meets the standards of  
10 financial solvency.

11 (d) A health insurer shall not enter into or renew a health care risk contract for Medicaid  
12 members with a provider organization that has not been certified as provided in § 23-17.28-3.

13 (e) Each health insurer shall provide the commissioner with a list of all provider  
14 organizations with which it has entered into a health care risk contract on an annual basis. If the  
15 commissioner has established one or more categories of risk contracts under § 42-14.5-3(t), the  
16 health insurer will indicate which category of risk contract each risk-bearing provider  
17 organization holds.

18 (f) The commissioner may establish additional requirements for health care risk contracts  
19 by regulation.

20 SECTION 4. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The  
21 Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended  
22 to read as follows:

23 **42-14.5-3. Powers and duties.**

24 The health insurance commissioner shall have the following powers and duties:

25 (a) To conduct quarterly public meetings throughout the state, separate and distinct from  
26 rate hearings pursuant to § 42-62-13, regarding the rates, services, and operations of insurers  
27 licensed to provide health insurance in the state; the effects of such rates, services, and operations  
28 on consumers, medical care providers, patients, and the market environment in which the insurers  
29 operate; and efforts to bring new health insurers into the Rhode Island market. Notice of not less  
30 than ten (10) days of the hearing(s) shall go to the general assembly, the governor, the Rhode  
31 Island Medical Society, the Hospital Association of Rhode Island, the director of health, the  
32 attorney general, and the chambers of commerce. Public notice shall be posted on the  
33 department's website and given in the newspaper of general circulation, and to any entity in  
34 writing requesting notice.

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

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

30 (d) To establish and provide guidance and assistance to a subcommittee ("the  
31 professional-provider-health-plan work group") of the advisory council created pursuant to  
32 subsection (c), composed of health-care providers and Rhode Island licensed health plans. This  
33 subcommittee shall include in its annual report and presentation before the house and senate  
34 finance committees the following information:



- 1 (1) A method whereby health plans shall disclose to contracted providers the fee  
2 schedules used to provide payment to those providers for services rendered to covered patients;
- 3 (2) A standardized provider application and credentials-verification process, for the  
4 purpose of verifying professional qualifications of participating health-care providers;
- 5 (3) The uniform health plan claim form utilized by participating providers;
- 6 (4) Methods for health maintenance organizations, as defined by § 27-41-2, and nonprofit  
7 hospital or medical-service corporations, as defined by chapters 19 and 20 of title 27, to make  
8 facility-specific data and other medical service-specific data available in reasonably consistent  
9 formats to patients regarding quality and costs. This information would help consumers make  
10 informed choices regarding the facilities and clinicians or physician practices at which to seek  
11 care. Among the items considered would be the unique health services and other public goods  
12 provided by facilities and clinicians or physician practices in establishing the most appropriate  
13 cost comparisons;
- 14 (5) All activities related to contractual disclosure to participating providers of the  
15 mechanisms for resolving health plan/provider disputes;
- 16 (6) The uniform process being utilized for confirming, in real time, patient insurance  
17 enrollment status, benefits coverage, including co-pays and deductibles;
- 18 (7) Information related to temporary credentialing of providers seeking to participate in  
19 the plan's network and the impact of the activity on health-plan accreditation;
- 20 (8) The feasibility of regular contract renegotiations between plans and the providers in  
21 their networks; and
- 22 (9) Efforts conducted related to reviewing impact of silent PPOs on physician practices.
- 23 (e) To enforce the provisions of Title 27 and Title 42 as set forth in § 42-14-5(d).
- 24 (f) To provide analysis of the Rhode Island affordable health plan reinsurance fund. The  
25 fund shall be used to effectuate the provisions of §§ 27-18.5-9 and 27-50-17.
- 26 (g) To analyze the impact of changing the rating guidelines and/or merging the individual  
27 health-insurance market, as defined in chapter 18.5 of title 27, and the small-employer-health-  
28 insurance market, as defined in chapter 50 of title 27, in accordance with the following:
- 29 (1) The analysis shall forecast the likely rate increases required to effect the changes  
30 recommended pursuant to the preceding subsection (g) in the direct-pay market and small-  
31 employer-health-insurance market over the next five (5) years, based on the current rating  
32 structure and current products.
- 33 (2) The analysis shall include examining the impact of merging the individual and small-  
34 employer markets on premiums charged to individuals and small-employer groups.

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

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

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

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

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

25 (8) The task force shall meet as necessary and include its findings in the annual report,  
26 and the commissioner shall include the information in the annual presentation before the house  
27 and senate finance committees.

28 (h) To establish and convene a workgroup representing health-care providers and health  
29 insurers for the purpose of coordinating the development of processes, guidelines, and standards  
30 to streamline health-care administration that are to be adopted by payors and providers of health-  
31 care services operating in the state. This workgroup shall include representatives with expertise  
32 who would contribute to the streamlining of health-care administration and who are selected from  
33 hospitals, physician practices, community behavioral-health organizations, each health insurer,  
34 and other affected entities. The workgroup shall also include at least one designee each from the

1 Rhode Island Medical Society, Rhode Island Council of Community Mental Health  
2 Organizations, the Rhode Island Health Center Association, and the Hospital Association of  
3 Rhode Island. The workgroup shall consider and make recommendations for:

4 (1) Establishing a consistent standard for electronic eligibility and coverage verification.

5 Such standard shall:

6 (i) Include standards for eligibility inquiry and response and, wherever possible, be  
7 consistent with the standards adopted by nationally recognized organizations, such as the Centers  
8 for Medicare and Medicaid Services;

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

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

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

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

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

23 (i) The use of the National Correct Coding Initiative code-edit policy by payors and  
24 providers in the state;

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

27 (iii) Use of Health Insurance Portability and Accountability Act standard group codes,  
28 reason codes, and remark codes by payors in electronic remittances sent to providers;

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

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

34 (vi) Nothing in this section, nor in the guidelines developed, shall inhibit an individual

1 payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of  
2 detecting and deterring fraudulent billing activities. The guidelines shall require that each payor  
3 disclose to the provider its adjudication decision on a claim that was denied or adjusted based on  
4 the application of such edits and that the provider have access to the payor's review and appeal  
5 process to challenge the payor's adjudication decision.

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

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

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

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

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

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

26 (4) To provide a report to the house and senate, on or before January 1, 2017, with  
27 recommendations for establishing guidelines and regulations for systems that give patients  
28 electronic access to their claims information, particularly to information regarding their  
29 obligations to pay for received medical services, pursuant to 45 C.F.R. 164.524.

30 (i) To issue an anti-cancer medication report. Not later than June 30, 2014 and annually  
31 thereafter, the office of the health insurance commissioner (OHIC) shall provide the senate  
32 committee on health and human services, and the house committee on corporations, with: (1)  
33 Information on the availability in the commercial market of coverage for anti-cancer medication  
34 options; (2) For the state employee's health benefit plan, the costs of various cancer-treatment

1 options; (3) The changes in drug prices over the prior thirty-six (36) months; and (4) Member  
2 utilization and cost-sharing expense.

3 (j) To monitor the adequacy of each health plan's compliance with the provisions of the  
4 federal Mental Health Parity Act, including a review of related claims processing and  
5 reimbursement procedures. Findings, recommendations, and assessments shall be made available  
6 to the public.

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

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

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

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

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

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

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

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

32 (1) Utilization review;

33 (2) Contracting; and

34 (3) Licensing and regulation.

1 (o) On or before February 3, 2015, the office of the health insurance commissioner shall  
2 submit a report to the general assembly and the governor that describes, analyzes, and proposes  
3 recommendations to improve compliance of insurers with the provisions of § 27-18-76 with  
4 regard to patients with mental-health and substance-use disorders.

5 (p) To work to ensure the health insurance coverage of behavioral health care under the  
6 same terms and conditions as other health care, and to integrate behavioral health parity  
7 requirements into the office of the health insurance commissioner insurance oversight and health  
8 care transformation efforts.

9 (q) To work with other state agencies to seek delivery system improvements that enhance  
10 access to a continuum of mental-health and substance-use disorder treatment in the state; and  
11 integrate that treatment with primary and other medical care to the fullest extent possible.

12 (r) To direct insurers toward policies and practices that address the behavioral health  
13 needs of the public and greater integration of physical and behavioral health care delivery.

14 (s) The office of the health insurance commissioner shall conduct an analysis of the  
15 impact of the provisions of § 27-38.2-1(i) on health insurance premiums and access in Rhode  
16 Island and submit a report of its findings to the general assembly on or before June 1, 2023.

17 (t) To protect the consumer interest through establishment, monitoring and enforcement  
18 of requirements related to health care risk contracts as defined in § 27-20.9-1 and risk-bearing  
19 provider organizations as defined in § 23-17.28-2, including the following:

20 (1) To certify certain provider organizations as eligible to enter into health care risk  
21 contracts for Medicaid populations, pursuant to chapter 17.28 of title 23.

22 (2) To establish multiple categories of health care risk contracts based on the amount of  
23 risk to which the risk-bearing provider organization is exposed. The health insurance  
24 commissioner may apply different standards and requirements related to health care risk contracts  
25 based on the category of the relevant risk contract.

26 (3) To evaluate the financial solvency of risk-bearing provider organizations and take  
27 additional actions pursuant to chapter 17.28 of title 23 and chapter 20.9 of title 27.

28 (4) To enact appropriate regulations to protect the consumer interest with respect to  
29 health care risk contracts.

30 SECTION 5. This act shall take effect upon passage.

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LC001874/SUB A  
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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF

A N A C T

RELATING TO HEALTH AND SAFETY - OVERSIGHT OF RISK-BEARING PROVIDER  
ORGANIZATIONS

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- 1           This act would provide the office of the health insurance commissioner with oversight of
- 2 risk-bearing provider organizations and health care risk contracts.
- 3           This act would take effect upon passage.

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LC001874/SUB A  
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