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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2011

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- PATIENT-CENTERED
MEDICAL HOME ACT

Introduced By: Representatives Naughton, McNamara, Kennedy, E Coderre, and Walsh

Date Introduced: February 08, 2011

Referred To: House Corporations

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 17.26

4 RHODE ISLAND ALL-PAYER PATIENT-CENTERED MEDICAL HOME ACT OF 2011

5 **23-17.26-1. Short title.** -- This chapter shall be known and may be cited as the “Rhode
6 Island All-Payer Patient-Centered Medical Home Act of 2011.”

7 **23-17.26-2. Legislative purpose and intent.** – (a) The general assembly recognizes
8 patient-centered medical homes as a valuable medical care tool The patient-centered medical
9 home, (hereinafter referred to as “PCMH”) is an approach to providing comprehensive primary
10 care for children, youth and adults. The patient-centered medical home is a health care setting that
11 facilitates partnerships between individual patients, and their personal physicians, physician
12 assistants and advanced practice nurses, and when appropriate, the patient’s family. Care is
13 facilitated by registries, information technology, health information exchange and other means to
14 assure that patients get the indicated care when and where they need and want it in a culturally
15 and linguistically appropriate manner. The goals of the patient-centered medical home are
16 improved delivery of comprehensive primary care and focus on better outcomes for patients,
17 more efficient payment to physicians and other clinicians, and better value, accountability and
18 transparency to purchasers and consumers. The patient-centered medical home changes the

1 interaction between patients and physicians and other clinicians from a series of episodic office
2 visits to an ongoing two-way relationship. The patient-centered medical home helps medical care
3 providers work to keep patients healthy instead of just healing them when they are sick. In the
4 patient-centered medical home, patients are active participants in managing their health with a
5 shared goal of staying as healthy as possible. The “PCMH” has the following characteristics to:

6 (1) Emphasize, enhance, and encourage the use of primary care, and include the use of
7 primary care physicians, advanced practice nurses, and physician assistants as personal clinicians;

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

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

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

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

18 (6) Focus initially on patients who have, or are at risk of developing, chronic health
19 conditions;

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

21 (8) Ensure the use of health information technology and systemic follow-up, including
22 the use of patient registries; and

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

26 **23-17.26-3. Definitions. --** As used in this chapter, the following terms shall have the
27 following meanings:

28 (1) “Director” means the director of the department of health.

29 (2) “Commissioner” means the health insurance commissioner.

30 (3) “Health insurer” means all entities licensed, or required to be licensed in this state that
31 offer health benefit plans in Rhode Island including, but not limited to, nonprofit hospital service
32 corporations and nonprofit medical service corporations established pursuant to chapter 27-19
33 and 27-20, and health maintenance organizations established pursuant to chapter 27-41 or as
34 defined in chapter 42-62, a fraternal benefit society or any other entity subject to state insurance

1 regulation that provides medical care on the basis of a periodic premium, paid directly or through
2 an association, trust or other intermediary, and issued, renewed, or delivered within or without the
3 state.

4 (4) "Health insurance plan" means any individual, general, blanket or group policy of
5 health, accident and sickness insurance issued by an insurer licensed to provide such insurance in
6 Rhode Island including, but not limited to, nonprofit hospital service corporations and nonprofit
7 medical service corporations established pursuant to chapters 27-19 and 27-20, and health
8 maintenance organizations established pursuant to chapter 27-41 or as defined in chapter 42-62.
9 The commissioner may by regulation define other health coverage as a health benefit plan for the
10 purposes of this chapter.

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

13 (6) "State health care program" means the medical assistance, RItE Care, and any other
14 health insurance program provided through the office of health and human services (OHHS) and
15 its component state agencies.

16 (7) "Patient-centered medical home" means a location that satisfies the characteristics
17 described in section 23-17.26-3, fulfills the standards determined by the patient-centered medical
18 home collaborative, and is designated as such by the commissioner.

19 (8) "Patient-centered medical home collaborative" means a community advisory council,
20 incorporating participants in the existing Rhode Island patient-centered medical home pilot
21 project, including, but not limited to, health insurers, physicians and other clinicians, employers,
22 the state health care program, relevant state agencies, community health centers, hospitals, other
23 providers, patients, and patient advocates which shall provide consultation and recommendations
24 to the director of health and the health insurance commissioner on all matters relating to proposed
25 regulations, development of standards, and development of payment mechanisms.

26 **23-17.26-4. Promotion of patient-centered medical home --Payment restructuring. --**

27 (a) Care coordination payments. The commissioner shall convene a patient-centered medical
28 home collaborative consisting of the entities described in subdivision 23-17.26-2(8). The
29 commissioner shall require participation in the collaborative by all of the health insurers
30 described in subdivision 23-17.26-2(3). The commissioner shall direct the collaborative to
31 develop, by July 1, 2012, a payment system that requires all health insurers to make per-person
32 care coordination payments to patient-centered medical homes, designated by the commissioner,
33 for providing care coordination services and directly managing on-site or employing care
34 coordinators as part of all health insurance plans offered in Rhode Island. The collaborative shall

1 provide guidance to the state health care program as to the appropriate payment system for the
2 state health care program to the same patient-centered medical homes, and the state health care
3 program must justify the reasons for any departure from this guidance to the collaborative. The
4 commissioner shall rely upon the director and the patient-centered medical home collaborative to
5 develop the standards for the patient-centered medical home to be used in the payment system
6 based on national models where feasible. The care coordination payments under this section may
7 be modified as the commissioner and the collaborative determine necessary, shall be consistent
8 among insurers and patient-centered medical homes, and shall be in addition to any other
9 incentive payments such as quality incentive payments. In developing the criteria for care
10 coordination payments, the commissioner shall consider the feasibility of including the additional
11 time and resources needed by patients with limited English-language skills, cultural differences,
12 or other barriers to health care. The commissioner may direct a schedule for phasing in-care
13 coordination fees.

14 (b) The care coordination payment system shall be in place through at least July 1, 2016.
15 Its continuation beyond that point shall depend upon the results of the evaluation reports filed
16 pursuant to section 23-17.26-6.

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

21 (1) Rewards high-quality, low-cost providers;

22 (2) Creates enrollee incentives to receive care from high-quality, low-cost providers;

23 (3) Fosters collaboration among providers to reduce cost shifting from one part of the
24 health continuum to another;

25 (4) Creates incentives that health care be provided in the least restrictive, most
26 appropriate setting; and

27 (5) Creates provider and/or enrollee incentives to promote personal health behaviors that
28 will prevent or control chronic disease including, but not limited to, tobacco cessation, weight
29 control, physical activity.

30 **23-17.26-5. Annual reports on implementation and administration.** -- The director
31 and commissioner shall report annually to the general assembly on the implementation and
32 administration of the patient-centered medical home model.

33 **23-17.26-6. Evaluation reports.** -- (a) The director and commissioner shall provide to
34 the general assembly comprehensive evaluations of the patient-centered medical home model

1 three (3) years and five (5) years after implementation. The evaluation must include:

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

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

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

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

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

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

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

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

18 **23-17.26-7. Alternative models.** -- Nothing in this chapter shall preclude the
19 development of alternative medical or health care home projects by an insurer, the director, the
20 commissioner or other state agencies or preclude insurers, the director, the commissioner or other
21 state agencies from establishing alternative models and payment mechanisms for persons who are
22 enrolled in integrated Medicare and Medicaid programs, are enrolled in managed-care long-term
23 care programs, are dually eligible for Medicare and Medicaid, are in the waiting period for
24 Medicare, or who have other primary coverage.

25 **23-17.26-8. Regulations.** -- The director of the department of health and the health
26 insurance commissioner shall develop rules and regulations to implement the provisions of this
27 chapter.

28 SECTION 2. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- PATIENT-CENTERED
MEDICAL HOME ACT

- 1 This act would create the “Rhode Island All-Payer Patient-Centered Medical Home Act.”
- 2 This act would take effect upon passage.

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