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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. 2014

A N A C T

RELATING TO HEALTH AND SAFETY - OFFICE OF HEALTH POLICY

Introduced By: Senators Miller, Picard, Sosnowski, DaPonte, and Ruggerio

Date Introduced: February 27, 2014

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Section 23-15-2 of the General Laws in Chapter 23-15 entitled "Determination of Need for New Health Care Equipment and New Institutional Health Services" is hereby amended to read as follows:

23-15-2. Definitions. -- As used in this chapter:

(1) "Affected person" means and includes the person whose proposal is being reviewed, or the applicant, health care facilities located within the state which provide institutional health services, the state medical society, the state osteopathic society, those voluntary nonprofit area-wide planning agencies that may be established in the state, the state budget office, the office of health insurance commissioner, any hospital or medical service corporation organized under the laws of the state, the statewide health coordinating council, contiguous health systems agencies, and those members of the public who are to be served by the proposed new institutional health services or new health care equipment.

(2) "Cost impact analysis" means a written analysis of the effect that a proposal to offer or develop new institutional health services or new health care equipment, if approved, will have on health care costs and shall include any detail that may be prescribed by the state agency in rules and regulations.

(3) "Director" means the director of the Rhode Island ~~state department of health~~ office of health policy.

(4) (i) "Health care facility" means any institutional health service provider, facility or

institution, place, building, agency, or portion of them, whether a partnership or corporation, whether public or private, whether organized for profit or not, used, operated, or engaged in providing health care services, which are limited to hospitals, nursing facilities, home nursing care provider, home care provider, hospice provider, inpatient rehabilitation centers (including drug and/or alcohol abuse treatment centers), certain facilities providing surgical treatment to patients not requiring hospitalization (surgi-centers, multi-practice physician ambulatory surgery centers and multi-practice podiatry ambulatory surgery centers) and facilities providing inpatient hospice care. Single-practice physician or podiatry ambulatory surgery centers (as defined in subdivisions 23-17-2(13) and 23-17-2(14), respectively) are exempt from the requirements of chapter 15 of this title; provided, however, that such exemption shall not apply if a single-practice physician or podiatry ambulatory surgery center is established by a medical practice group (as defined in section 5-37-1) within two (2) years following the formation of such medical practice group, when such medical practice group is formed by the merger or consolidation of two (2) or more medical practice groups or the acquisition of one medical practice group by another medical practice group. The term "health care facility" does not include Christian Science institutions (also known as Christian Science nursing facilities) listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

(ii) Any provider of hospice care who provides hospice care without charge shall be exempt from the provisions of this chapter.

(5) "Health care provider" means a person who is a direct provider of health care services (including but not limited to physicians, dentists, nurses, podiatrists, physician assistants, or nurse practitioners) in that the person's primary current activity is the provision of health care services for persons.

(6) "Health services" means organized program components for preventive, assessment, maintenance, diagnostic, treatment, and rehabilitative services provided in a health care facility.

(7) "Health services council" means the advisory body to the Rhode Island ~~state department of health~~ office of health policy established in accordance with chapter 17 of this title, appointed and empowered as provided to serve as the advisory body to the state agency in its review functions under this chapter.

(8) "Institutional health services" means health services provided in or through health care facilities and includes the entities in or through which the services are provided.

(9) "New health care equipment" means any single piece of medical equipment (and any components which constitute operational components of the piece of medical equipment)

proposed to be utilized in conjunction with the provision of services to patients or the public, the capital costs of which would exceed two million two hundred fifty thousand dollars ($2,250,000); provided, however, that the state agency shall exempt from review any application which proposes one for one equipment replacement as defined in regulation. Further, beginning July 1, 2012 and each July thereafter the amount shall be adjusted by the percentage of increase in the consumer price index for all urban consumers (CPI-U) as published by the United States department of labor statistics as of September 30 of the prior calendar year.

(10) "New institutional health services" means and includes:

(i) Construction, development, or other establishment of a new health care facility.

(ii) Any expenditure except acquisitions of an existing health care facility which will not result in a change in the services or bed capacity of the health care facility by or on behalf of an existing health care facility in excess of five million two hundred fifty thousand dollars ($5,250,000) which is a capital expenditure including expenditures for predevelopment activities; provided further, beginning July 1, 2012 and each July thereafter the amount shall be adjusted by the percentage of increase in the consumer price index for all urban consumers (CPI-U) as published by the United States department of labor statistics as of September 30 of the prior calendar year.

(iii) Where a person makes an acquisition by or on behalf of a health care facility or health maintenance organization under lease or comparable arrangement or through donation, which would have required review if the acquisition had been by purchase, the acquisition shall be deemed a capital expenditure subject to review.

(iv) Any capital expenditure which results in the addition of a health service or which changes the bed capacity of a health care facility with respect to which the expenditure is made, except that the state agency may exempt from review by rules and regulations promulgated for this chapter any bed reclassifications made to licensed nursing facilities and annual increases in licensed bed capacities of nursing facilities that do not exceed the greater of ten (10) beds or ten percent (10%) of facility licensed bed capacity and for which the related capital expenditure does not exceed two million dollars ($2,000,000).

(v) Any health service proposed to be offered to patients or the public by a health care facility which was not offered on a regular basis in or through the facility within the twelve (12) month period prior to the time the service would be offered, and which increases operating expenses by more than one million five hundred thousand dollars ($1,500,000), except that the state agency may exempt from review by rules and regulations promulgated for this chapter any health service involving reclassification of bed capacity made to licensed nursing facilities.

Further beginning July 1, 2012 and each July thereafter the amount shall be adjusted by the percentage of increase in the consumer price index for all urban consumers (CPI-U) as published by the United States department of labor statistics as of September 30 of the prior calendar year.

(vi) Any new or expanded tertiary or specialty care service, regardless of capital expense or operating expense, as defined by and listed in regulation, the list not to exceed a total of twelve (12) categories of services at any one time and shall include full body magnetic resonance imaging and computerized axial tomography; provided, however, that the state agency shall exempt from review any application which proposes one for one equipment replacement as defined by and listed in regulation. Acquisition of full body magnetic resonance imaging and computerized axial tomography shall not require a certificate of need review and approval by the state agency if satisfactory evidence is provided to the state agency that it was acquired for under one million dollars ($1,000,000) on or before January 1, 2010 and was in operation on or before July 1, 2010.

(11) "Person" means any individual, trust or estate, partnership, corporation (including associations, joint stock companies, and insurance companies), state or political subdivision, or instrumentality of a state.

(12) "Predevelopment activities" means expenditures for architectural designs, plans, working drawings and specifications, site acquisition, professional consultations, preliminary plans, studies, and surveys made in preparation for the offering of a new institutional health service.

(13) "State agency" means the Rhode Island ~~state department of health~~ office of health policy.

(14) "To develop" means to undertake those activities which, on their completion, will result in the offering of a new institutional health service or new health care equipment or the incurring of a financial obligation, in relation to the offering of that service.

(15) "To offer" means to hold oneself out as capable of providing, or as having the means for the provision of, specified health services or health care equipment.

SECTION 2. Section 23-17.12-2 of the General Laws in Chapter 23-17.12 entitled "Health Care Services - Utilization Review Act" is hereby amended to read as follows:

23-17.12-2. Definitions. -- As used in this chapter, the following terms are defined as follows:

(1) "Adverse determination" means a utilization review decision by a review agent not to authorize a health care service. A decision by a review agent to authorize a health care service in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute

an adverse determination if the review agent and provider are in agreement regarding the decision. Adverse determinations include decisions not to authorize formulary and nonformulary medication.

(2) "Appeal" means a subsequent review of an adverse determination upon request by a patient or provider to reconsider all or part of the original decision.

(3) "Authorization" means the review agent's utilization review, performed according to subsection 23-17.12-2(20), concluded that the allocation of health care services of a provider, given or proposed to be given to a patient was approved or authorized.

(4) "Benefit determination" means a decision of the enrollee's entitlement to payment for covered health care services as defined in an agreement with the payor or its delegate.

(5) "Certificate" means a certificate of registration granted by the director to a review agent.

(6) "Complaint" means a written expression of dissatisfaction by a patient, or provider. The appeal of an adverse determination is not considered a complaint.

(7) "Concurrent assessment" means an assessment of the medical necessity and/or appropriateness of health care services conducted during a patient's hospital stay or course of treatment. If the medical problem is ongoing, this assessment may include the review of services after they have been rendered and billed. This review does not mean the elective requests for clarification of coverage or claims review or a provider's internal quality assurance program except if it is associated with a health care financing mechanism.

(8) "Department" means the ~~department of health~~ office of health policy.

(9) "Director" means the director of the ~~department of health~~ office of health policy.

(10) "Emergent health care services" has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42 as may be amended from time to time and includes those resources provided in the event of the sudden onset of a medical, mental health, or substance abuse or other health care condition manifesting itself by acute symptoms of a severity (e.g. severe pain) where the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part.

(11) "Patient" means an enrollee or participant in all hospital or medical plans seeking health care services and treatment from a provider.

(12) "Payor" means a health insurer, self-insured plan, nonprofit health service plan, health insurance service organization, preferred provider organization, health maintenance organization or other entity authorized to offer health insurance policies or contracts or pay for

the delivery of health care services or treatment in this state.

(13) "Practitioner" means any person licensed to provide or otherwise lawfully providing health care services, including, but not limited to, a physician, dentist, nurse, optometrist, podiatrist, physical therapist, clinical social worker, or psychologist.

(14) "Prospective assessment" means an assessment of the medical necessity and/or appropriateness of health care services prior to services being rendered.

(15) "Provider" means any health care facility, as defined in section 23-17-2 including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioners identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

(16) "Retrospective assessment" means an assessment of the medical necessity and/or appropriateness of health care services that have been rendered. This shall not include reviews conducted when the review agency has been obtaining ongoing information.

(17) "Review agent" means a person or entity or insurer performing utilization review that is either employed by, affiliated with, under contract with, or acting on behalf of:

(i) A business entity doing business in this state;

(ii) A party that provides or administers health care benefits to citizens of this state, including a health insurer, self-insured plan, non-profit health service plan, health insurance service organization, preferred provider organization or health maintenance organization authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state; or

(iii) A provider.

(18) "Same or similar specialty" means a practitioner who has the appropriate training and experience that is the same or similar as the attending provider in addition to experience in treating the same problems to include any potential complications as those under review.

(19) "Urgent health care services" has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42 as may be amended from time to time and includes those resources necessary to treat a symptomatic medical, mental health, or substance abuse or other health care condition requiring treatment within a twenty-four (24) hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to be emergent health care services as defined in subdivision (10).

(20) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and/or appropriateness of the allocation of health care services of a provider,

given or proposed to be given to a patient. Utilization review does not include:

(i) Elective requests for the clarification of coverage; or

(ii) Benefit determination; or

(iii) Claims review that does not include the assessment of the medical necessity and appropriateness; or

(iv) A provider's internal quality assurance program except if it is associated with a health care financing mechanism; or

(v) The therapeutic interchange of drugs or devices by a pharmacy operating as part of a licensed inpatient health care facility; or

(vi) The assessment by a pharmacist licensed pursuant to the provisions of chapter 19 of title 5 and practicing in a pharmacy operating as part of a licensed inpatient health care facility in the interpretation, evaluation and implementation of medical orders, including assessments and/or comparisons involving formularies and medical orders.

(21) "Utilization review plan" means a description of the standards governing utilization review activities performed by a private review agent.

(22) "Health care services" means and includes an admission, diagnostic procedure, therapeutic procedure, treatment, extension of stay, the ordering and/or filling of formulary or nonformulary medications, and any other services, activities, or supplies that are covered by the patient's benefit plan.

(23) "Therapeutic interchange" means the interchange or substitution of a drug with a dissimilar chemical structure within the same therapeutic or pharmacological class that can be expected to have similar outcomes and similar adverse reaction profiles when given in equivalent doses, in accordance with protocols approved by the president of the medical staff or medical director and the director of pharmacy.

SECTION 3. Section 23-17.13-2 of the General Laws in Chapter 23-17.13 entitled "Health Care Accessibility and Quality Assurance Act" is hereby amended to read as follows:

23-17.13-2. Definitions. -- As used in this chapter:

(1) "Adverse decision" means any decision by a review agent not to certify an admission, service, procedure, or extension of stay. A decision by a reviewing agent to certify an admission, service, or procedure in an alternative treatment setting, or to certify a modified extension of stay, shall not constitute an adverse decision if the reviewing agent and the requesting provider are in agreement regarding the decision.

(2) "Contractor" means a person/entity that:

(i) Establishes, operates or maintains a network of participating providers;

(ii) Contracts with an insurance company, a hospital or medical or dental service plan, an employer, whether under written or self insured, an employee organization, or any other entity providing coverage for health care services to administer a plan; and/or

(iii) Conducts or arranges for utilization review activities pursuant to chapter 17.12 of this title.

(3) "Direct service ratio" means the amount of premium dollars expended by the plan for covered services provided to enrollees on a plan's fiscal year basis.

(4) "Director" means the director of the ~~department of health~~ office of health policy.

(5) "Emergency services" has the same meaning as the meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42, as may be amended from time to time, and includes the sudden onset of a medical or mental condition that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily organ or part.

(6) "Health care entity" means a licensed insurance company, hospital, or dental or medical service plan or health maintenance organization, or a contractor as described in subdivision (2), that operates a health plan.

(7) "Health care services" includes, but is not limited to, medical, mental health, substance abuse, and dental services.

(8) "Health plan" means a plan operated by a health care entity as described in subdivision (6) that provides for the delivery of care services to persons enrolled in the plan through:

(i) Arrangements with selected providers to furnish health care services; and/or

(ii) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan.

(9) "Provider" means a physician, hospital, pharmacy, laboratory, dentist, or other state licensed or other state recognized provider of health care services or supplies, and whose services are recognized pursuant to 213(d) of the Internal Revenue Code, 26 U.S.C. section 213(d), that has entered into an agreement with a health care entity as described in subdivision (6) or contractor as described in subdivision (2) to provide these services or supplies to a patient enrolled in a plan.

(10) "Provider incentive plan" means any compensation arrangement between a health care entity or plan and a provider or provider group that may directly or indirectly have the effect of reducing or limiting services provided with respect to an individual enrolled in a plan.

(11) "Qualified health plan" means a plan that the director of the ~~department of health~~ office of health policy certified, upon application by the program, as meeting the requirements of this chapter.

(12) "Qualified utilization review program" means utilization review program that meets the requirements of chapter 17.12 of this title.

(13) "Most favored rate clause" means a provision in a provider contract whereby the rates or fees to be paid by a health plan are fixed, established or adjusted to be equal to or lower than the rates or fees paid to the provider by any other health plan or third party payor.

SECTION 4. Sections 23-17.14-4, 23-17.14-5, 23-17.14-7, 23-17.14-8, 23-17.14-10, 23-17.14-11, 23-17.14-12 and 23-17.14-31 of the General Laws in Chapter 23-17.14 entitled "The Hospital Conversions Act" are hereby amended to read as follows:

23-17.14-4. Definitions. -- For purposes of this chapter:

(1) "Acquiree" means the person or persons that lose(s) any ownership or control in the new hospital as a result of a conversion, as the terms "conversion," "new hospital," and "person(s)" are defined within this chapter;

(2) "Acquiror" means the person or persons which gain(s) an ownership or control in the new hospital as a result of a conversion, as the terms "conversion," "new hospital," and "person(s)" are defined within this chapter;

(3) "Affected community" means any city or town within the state wherein an existing hospital is physically located and/or those cities and towns whose inhabitants are regularly served by the existing hospital;

(4) "Charity care" is defined as health care services provided by a hospital without charge to a patient and for which the hospital does not and has not expected payment;

(5) "Community benefit" means the provision of hospital services that meet the ongoing needs of the community for primary and emergency care in a manner that enables families and members of the community to maintain relationships with person who are hospitalized or are receiving hospital services, and shall also include, but not be limited to charity care and uncompensated care;

(6) "Conversion" means any transfer by a person or persons of an ownership or membership interest or authority in a hospital, or the assets of a hospital, whether by purchase, merger, consolidation, lease, gift, joint venture, sale, or other disposition which results in a change of ownership or control or possession of twenty percent (20%) or greater of the members or voting rights or interests of the hospital or of the assets of the hospital or pursuant to which, by virtue of the transfer, a person, together with all persons affiliated with the person, holds or owns,

in the aggregate, twenty percent (20%) or greater of the membership or voting rights or interests of the hospital or of the assets of the hospital, or the removal, addition or substitution of a partner which results in a new partner gaining or acquiring a controlling interest in the hospital, or any change in membership which results in a new person gaining or acquiring a controlling vote in the hospital;

(7) "Current conflict of interest forms" means conflict of interest forms signed within one year prior to the date the application is submitted in the same form as submitted to auditors for the transacting parties in connection with the preparation of financial statements, or in such other form as is acceptable to the attorney general, together with a description of any conflicts of interest that have been discovered by or disclosed to a transacting party since the date of such conflict of interest forms;

(8) "Department" means the ~~department of health~~ office of health policy. However "departments" shall mean the ~~department of health~~ office of health policy and the department of the attorney general;

(9) "Director" means the director of the ~~department of health~~ office of health policy;

(10) "Existing hospital" means the acquiree hospital as it exists prior to the acquisition;

(11) "For-profit corporation" means a legal entity formed for the purpose of transacting business which has as any one of its purposes pecuniary profit;

(12) "Hospital" means a person or governmental entity licensed in accordance with chapter 17 of this title to establish, maintain and operate a hospital;

(13) "New hospital" means the acquiree hospital as it exists after the completion of a conversion;

(14) "Not-for-profit corporation means a legal entity formed for some charitable or benevolent purpose and not-for-profit which has been exempted from taxation pursuant to Internal Revenue Code section 501(c)(3), 26 U.S.C. section 501(c)(3);

(15) "Person" means any individual, trust or estate, partnership, corporation (including associations, joint stock companies and insurance companies), state or political subdivision or instrumentality of the state;

(16) "Senior managers" or "senior management" means executives and senior level managers of a transacting party;

(17) "Transacting parties" means the acquiree and the acquiror;

(18) "Uncompensated care" means a combination of free care, which the hospital provides at no cost to the patient, bad debt, which the hospital bills for but does not collect, and less than full Medicaid reimbursement amounts.

23-17.14-5. ~~Prior approval required -- Department of attorney general and department of health. --~~ Prior approval required -- Department of attorney general and office of health policy. -- (a) A conversion shall require review and approval from the department of attorney general and from the ~~department of health~~ office of health policy in accordance with the provisions of this chapter; except as provided for under section 23-17.14-12.1 hereof, but shall remain subject to the authority of the attorney general pursuant to section 23-17.14-21 hereof.

(b) The review by the departments shall occur concurrently, and neither department shall delay its review or determination because the other department has not completed its review or issued its determination. The applicant may request that the review by the department occur concurrently with the review of any relevant federal regulatory authority.

23-17.14-7. ~~Review process of the department of attorney general and the department of health and review criteria by department of attorney general. --~~ Review process of the department of attorney general and the office of health policy and review criteria by department of attorney general. -- (a) The department of attorney general shall review all conversions involving a hospital in which one or more of the transacting parties involves a for profit corporation as the acquiror and a not for profit corporation as the acquiree.

(b) In reviewing proposed conversions in accordance with this section and section 23-17.14-10, the department of attorney general and ~~department of health~~ office of health policy shall adhere to the following process:

(1) Within thirty (30) days after receipt of an initial application, the department of attorney general and ~~department of health~~ office of health policy shall jointly advise the applicant, in writing, whether the application is complete, and, if not, shall specify all additional information the applicant is required to provide;

(2) The applicant will submit the additional information within thirty (30) working days. If the additional information is submitted within the thirty (30) day period, the department of attorney general and ~~department of health~~ office of health policy will have ten (10) working days within which to determine acceptability of the additional information. If the additional information is not submitted by the applicant within the thirty (30) day period or if either agency determines the additional information submitted by the applicant is insufficient, the application will be rejected without prejudice to the applicant's right to resubmit, the rejection to be accompanied by a detailed written explanation of the reasons for rejection. If the department of attorney general and ~~department of health~~ office of health policy determine the additional information to be as requested, the applicant will be notified, in writing, of the date of acceptance

of the application;

(3) Within thirty (30) working days after acceptance of the initial application, the department of attorney general shall render its determination on confidentiality pursuant to section 23-17.14-32 and the department of attorney general and ~~department of health~~ office of health policy shall publish notice of the application in a newspaper of general circulation in the state and shall notify by United States mail any person who has requested notice of the filing of the application. The notice shall:

(i) State that an initial application has been received and accepted for review,

(ii) State the names of the transacting parties,

(iii) State the date by which a person may submit written comments to the department of attorney general or ~~department of health~~ office of health policy; and

(iv) Provide notice of the date, time and place of informational meeting open to the public which shall be conducted within sixty (60) days of the date of the notice;

(4) The department of attorney general and ~~department of health~~ office of health policy shall each approve, approve with conditions directly related to the proposed conversion, or disapprove the application within one hundred twenty (120) days of the date of acceptance of the application.

(c) In reviewing an application pursuant to subsection (a) the department of the attorney general shall consider the following criteria:

(1) Whether the proposed conversion will harm the public's interest in trust property given, devised, or bequeathed to the existing hospital for charitable, educational or religious purposes located or administered in this state;

(2) Whether a trustee or trustees of any charitable trust located or administered in this state will be deemed to have exercised reasonable care, diligence, and prudence in performing as a fiduciary in connection with the proposed conversion;

(3) Whether the board established appropriate criteria in deciding to pursue a conversion in relation to carrying out its mission and purposes;

(4) Whether the board formulated and issued appropriate requests for proposals in pursuing a conversion;

(5) Whether the board considered the proposed conversion as the only alternative or as the best alternative in carrying out its mission and purposes;

(6) Whether any conflict of interest exists concerning the proposed conversion relative to members of the board, officers, directors, senior management, experts or consultants engaged in connection with the proposed conversion including, but not limited to, attorneys, accountants,

investment bankers, actuaries, health care experts, or industry analysts;

(7) Whether individuals described in subdivision (c)(6) were provided with contracts or consulting agreements or arrangements which included pecuniary rewards based in whole, or in part on the contingency of the completion of the conversion;

(8) Whether the board exercised due care in engaging consultants with the appropriate level of independence, education, and experience in similar conversions;

(9) Whether the board exercised due care in accepting assumptions and conclusions provided by consultants engaged to assist in the proposed conversion;

(10) Whether the board exercised due care in assigning a value to the existing hospital and its charitable assets in proceeding to negotiate the proposed conversion;

(11) Whether the board exposed an inappropriate amount of assets by accepting in exchange for the proposed conversion future or contingent value based upon success of the new hospital;

(12) Whether officers, directors, board members or senior management will receive future contracts in existing, new, or affiliated hospital or foundations;

(13) Whether any members of the board will retain any authority in the new hospital;

(14) Whether the board accepted fair consideration and value for any management contracts made part of the proposed conversion;

(15) Whether individual officers, directors, board members or senior management engaged legal counsel to consider their individual rights or duties in acting in their capacity as a fiduciary in connection with the proposed conversion;

(16) Whether the proposed conversion results in an abandonment of the original purposes of the existing hospital or whether a resulting entity will depart from the traditional purposes and mission of the existing hospital such that a cy pres proceeding would be necessary;

(17) Whether the proposed conversion contemplates the appropriate and reasonable fair market value;

(18) Whether the proposed conversion was based upon appropriate valuation methods including, but not limited to, market approach, third party report or fairness opinion;

(19) Whether the conversion is proper under the Rhode Island Nonprofit Corporation Act;

(20) Whether the conversion is proper under applicable state tax code provisions;

(21) Whether the proposed conversion jeopardizes the tax status of the existing hospital;

(22) Whether the individuals who represented the existing hospital in negotiations avoided conflicts of interest;

(23) Whether officers, board members, directors, or senior management deliberately acted or failed to act in a manner that impacted negatively on the value or purchase price;

(24) Whether the formula used in determining the value of the existing hospital was appropriate and reasonable which may include, but not be limited to factors such as: the multiple factor applied to the "EBITDA" -- earnings before interest, taxes, depreciation, and amortization; the time period of the evaluation; price/earnings multiples; the projected efficiency differences between the existing hospital and the new hospital; and the historic value of any tax exemptions granted to the existing hospital;

(25) Whether the proposed conversion appropriately provides for the disposition of proceeds of the conversion that may include, but not be limited to:

(i) Whether an existing entity or a new entity will receive the proceeds;

(ii) Whether appropriate tax status implications of the entity receiving the proceeds have been considered;

(iii) Whether the mission statement and program agenda will be or should be closely related with the purposes of the mission of the existing hospital;

(iv) Whether any conflicts of interest arise in the proposed handling of the conversion's proceeds;

(v) Whether the bylaws and articles of incorporation have been prepared for the new entity;

(vi) Whether the board of any new or continuing entity will be independent from the new hospital;

(vii) Whether the method for selecting board members, staff, and consultants is appropriate;

(viii) Whether the board will comprise an appropriate number of individuals with experience in pertinent areas such as foundations, health care, business, labor, community programs, financial management, legal, accounting, grant making and public members representing diverse ethnic populations and the interests of the affected community;

(ix) Whether the size of the board and proposed length of board terms are sufficient;

(26) Whether the transacting parties are in compliance with the Charitable Trust Act, chapter 9 of title 18; and

(27) Whether a right of first refusal to repurchase the assets has been retained.

(28) Whether the character, commitment, competence and standing in the community, or any other communities served by the transacting parties are satisfactory;

(29) Whether a control premium is an appropriate component of the proposed

conversion; and

(30) Whether the value of assets factored in the conversion is based on past performance or future potential performance.

23-17.14-8. ~~Review process and review criteria by department of health for conversions involving for-profit corporation as acquiror. --~~ Review process and review criteria by office of health policy for conversions involving for-profit corporation as acquiror. -- (a) The ~~department~~ office of health policy shall review all proposed conversions involving a hospital in which one or more of the transacting parties involves a for-profit corporation as the acquiror and a not-for-profit corporation as the acquiree.

(b) In reviewing an application for a conversion involving hospitals in which one or more of the transacting parties is a for-profit corporation as the acquiror the ~~department~~ office of health policy shall consider the following criteria:

(1) Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed transacting parties, are satisfactory;

(2) Whether sufficient safeguards are included to assure the affected community continued access to affordable care;

(3) Whether the transacting parties have provided clear and convincing evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community;

(4) Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital;

(5) Whether the transacting parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workforce;

(6) Whether the transacting parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring;

(7) Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state; and

(8) Whether the acquiror has demonstrated that it has satisfactorily met the terms and conditions of approval for any previous conversion pursuant to an application submitted under section 23-17.14-6.

23-17.14-10. ~~Review process of department of attorney general and department of health and criteria by department of attorney general -- Conversions limited to not for-~~

~~profit corporations. --~~ **Review process of departments and criteria by department of attorney general -- Conversions limited to not-for- profit corporations. --** (a) In reviewing an application of a conversion involving a hospital in which the transacting parties are limited to not-for-profit corporations, except as provided in section 23-17.14-12.1, the department of attorney general and ~~department of health~~ the office of health policy shall adhere to the following process:

(1) Within thirty (30) days after receipt of an initial application, the department of attorney general and ~~department of health~~ the office of health policy shall jointly advise the applicant, in writing, whether the application is complete, and, if not, shall specify all additional information the applicant is required to provide;

(2) The applicant will submit the additional information within thirty (30) working days. If the additional information is submitted within the thirty (30) day period, the department of attorney general and ~~department of health~~ the office of health policy will have ten (10) working days within which to determine acceptability of the additional information. If the additional information is not submitted by the applicant within the thirty (30) day period or if either agency determines the additional information submitted by the applicant is insufficient, the application will be rejected without prejudice to the applicant's right to resubmit, the rejection to be accompanied by a detailed written explanation of the reasons for rejection. If the department of attorney general and ~~department of health~~ the office of health policy determine the additional information to be as requested, the applicant will be notified, in writing, of the date of acceptance of the application;

(3) Within thirty (30) working days after acceptance of the initial application, the department of attorney general shall render its determination on confidentiality pursuant to section 23-17.14-32 and the department of attorney general and ~~department of health~~ the office of health policy shall publish notice of the application in a newspaper of general circulation in the state and shall notify by United States mail any person who has requested notice of the filing of the application. The notice shall:

(i) State that an initial application has been received and accepted for review,

(ii) State the names of the transacting parties,

(iii) State the date by which a person may submit written comments to the department of attorney general or ~~department of health~~ the office of health policy, and

(iv) Provide notice of the date, time and place of informational meeting open to the public which shall be conducted within sixty (60) days of the date of the notice;

(4) The department of attorney general and ~~department of health~~ the office of health policy shall each approve, approve with conditions directly related to the proposed conversion, or

disapprove the application within one hundred twenty (120) days of the date of acceptance of the application.

(b) In reviewing an application of a conversion involving a hospital in which the transacting parties are limited to not-for-profit corporations, the department of attorney general may consider the following criteria:

(1) Whether the proposed conversion will harm the public's interest in trust property given, devised, or bequeathed to the existing hospital for charitable, educational or religious purposes located or administered in this state;

(2) Whether a trustee or trustees of any charitable trust located or administered in this state will be deemed to have exercised reasonable care, diligence, and prudence in performing as a fiduciary in connection with the proposed conversion;

(3) Whether the board established appropriate criteria in deciding to pursue a conversion in relation to carrying out its mission and purposes;

(4) Whether the board considered the proposed conversion as the only alternative or as the best alternative in carrying out its mission and purposes;

(5) Whether any conflict of interest exists concerning the proposed conversion relative to members of the board, officers, directors, senior management, experts or consultants engaged in connection with the proposed conversion including, but not limited to, attorneys, accountants, investment bankers, actuaries, health care experts, or industry analysts;

(6) Whether individuals described in subdivision (b)(5) were provided with contracts or consulting agreements or arrangements which included pecuniary rewards based in whole, or in part on the contingency of the completion of the conversion;

(7) Whether the board exercised due care in engaging consultants with the appropriate level of independence, education, and experience in similar conversions;

(8) Whether the board exercised due care in accepting assumptions and conclusions provided by consultants engaged to assist in the proposed conversion;

(9) Whether officers, directors, board members or senior management will receive future contracts;

(10) Whether any members of the board will retain any authority in the new hospital;

(11) Whether the board accepted fair consideration and value for any management contracts made part of the proposed conversion;

(12) Whether individual officers, directors, board members or senior management engaged legal counsel to consider their individual rights or duties in acting in their capacity as a fiduciary in connection with the proposed conversion;

(13) Whether the proposed conversion results in an abandonment of the original purposes of the existing hospital or whether a resulting entity will depart from the traditional purposes and mission of the existing hospital such that a cy pres proceeding would be necessary;

(14) Whether the proposed conversion contemplates the appropriate and reasonable fair market value;

(15) Whether the proposed conversion was based upon appropriate valuation methods including, but not limited to, market approach, third-party report or fairness opinion;

(16) Whether the conversion is proper under the Rhode Island Nonprofit Corporation Act;

(17) Whether the conversion is proper under applicable state tax code provisions;

(18) Whether the proposed conversion jeopardizes the tax status of the existing hospital;

(19) Whether the individuals who represented the existing hospital in negotiations avoided conflicts of interest;

(20) Whether officers, board members, directors, or senior management deliberately acted or failed to act in a manner that impacted negatively on the value or purchase price;

(21) Whether the transacting parties are in compliance with the Charitable Trust Act, chapter 9 of title 18.

23-17.14-11. ~~**Criteria for the department of health -- Conversions limited to not-for-profit corporations. --**~~ **Criteria for the office of health policy -- Conversions limited to not-for-profit corporations. --** In reviewing an application of a conversion involving a hospital in which the transacting parties are limited to not-for-profit corporations, the ~~department~~ office of health policy shall consider the following criteria:

(1) Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed transacting parties are satisfactory;

(2) Whether sufficient safeguards are included to assure the affected community continued access to affordable care;

(3) Whether the transacting parties have provided satisfactory evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community;

(4) Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital;

(5) Whether the transacting parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workforce;

(6) Whether the transacting parties have appropriately accounted for employment needs

at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring;

(7) Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state.

23-17.14-12. ~~Review process by department of health for conversions involving for-profit hospital as the acquiree. --~~ Review process by office of health policy for conversions involving for-profit hospital as the acquiree. -- The ~~department of health~~ office of health policy shall review all proposed conversions involving a for-profit hospital as the acquiree and either a for-profit corporation or a not-for-profit hospital or corporation as the acquiror in accordance with the provisions for change of effective control pursuant to sections 23-17-14.3 and 23-17-14.4.

23-17.14-31. ~~Powers of the department of health. --~~ Powers of the office of health policy. --The ~~department~~ office of health policy may adopt rules, including measurable standards, as may be necessary to accomplish the purpose of this chapter. In doing so, the ~~department~~ office of health policy shall review other departmental regulations that may have duplicative requirements, including change of effective control regulations and processes, determination of need requirements and application requirements under section 23-17.14-18, if applicable, and may streamline the process by eliminating duplicative requirements and providing for concurrent regulatory review and combined hearings to the maximum extent possible to promote efficiency and avoid duplication of effort and resources.

SECTION 5. Section 23-17.17-2 of the General Laws in Chapter 23-17.17 entitled "Health Care Quality Program" is hereby amended to read as follows:

23-17.17-2. Definitions. -- (a) "Clinical outcomes" means information about the results of patient care and treatment.

(b) "Director" means the director of the ~~department of health~~ office of health policy or his or her duly authorized agent.

(c) "Health care facility" has the same meaning as contained in the regulations promulgated by the director of ~~health~~ the office of health policy pursuant to chapter 17 of this title.

(d) "Health care provider" means any physician, or other licensed practitioners with responsibility for the care, treatment, and services rendered to a patient.

(e) "Hospital-acquired infection" means a localized or systemic condition: (1) that results from adverse reaction to the presence of an infectious agent(s) or its toxin(s); and (2) may include infections not present or exhibiting signs and symptoms at the time of admission to the hospital as

determined by the ~~department~~ office of health policy with recommendations from the health care quality steering committee with advice from the hospital acquired infections and prevention advisory committee.

(f) "Insurer" means any entity subject to the insurance laws and regulations of this state, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including, without limitation, an insurance company offering accident and sickness insurance, a health maintenance organization, as defined by section 27-41-1, a nonprofit hospital or medical service corporation, as defined by chapters 27-19 and 27-20, or any other entity providing a plan of health insurance or health benefits.

(g) "Patient satisfaction" means the degree to which the facility or provider meets or exceeds the patients' expectations as perceived by the patient by focusing on those aspects of care that the patient can judge.

(h) "Performance measure" means a quantitative tool that provides an indication of an organization's performance in relation to a specified process or outcome.

(i) "Quality of care" means the result or outcome of health care efforts.

(j) "Reporting program" means an objective feedback mechanism regarding individual or facility performance that can be used internally to support performance improvement activities and externally to demonstrate accountability to the public and other purchasers, payers, and stakeholders.

(k) "Risk-adjusted" means the use of statistically valid techniques to account for patient variables that may include, but need not to be limited to, age, chronic disease history, and physiologic data.

(l) "Consumer information" means, but is not limited to, providing written recommendations to every individual before and during their hospitalization for the purpose of preventing hospital acquired infections. In emergency hospitalizations, written guidelines shall be given within a reasonable period of time.

SECTION 6. Section 23-81-3.1 of the General Laws in Chapter 23-81 entitled "Rhode Island Coordinated Health Planning Act of 2006" is hereby amended to read as follows:

23-81-3.1. ~~Establishment of health care planning and accountability advisory council.~~ Establishment of health care planning advisory council. -- ~~Contingent upon funding:~~

(a) The health care planning ~~and accountability~~ advisory council shall be appointed by ~~the secretary of the executive office of health and human services and the health insurance commissioner~~ the director of the office of health policy, no later than ~~September 30, 2011~~ March

15, 2015, to develop and promote recommendations on the health care system in the form of health planning documents described in subsection 23-81-4(a).

~~(b) The secretary of the executive office of health and human services and the health insurance commissioner shall serve as co-chairs of the health care planning council.~~

~~(c) The department of health, in coordination with the executive office of health and human services and the office of the health insurance commissioner, shall be the principal staff agency of the council to develop analysis of the health care system for use by the council, including, but not limited to, health planning studies and health plan documents; making recommendations for the council to consider for adoption, modification and promotion; and ensuring the continuous and efficient functioning of the health care planning council.~~

~~(d) The health care planning council shall consist of, but not be limited to, the following:~~

~~(1) Five (5) consumer representatives. A consumer is defined as someone who does not directly or through a spouse or partner receive any of his/her livelihood from the health care system. Consumers may be nominated from the labor unions in Rhode Island; the health care consumer advocacy organizations in Rhode Island, the business community; and organizations representing the minority community who have an understanding of the linguistic and cultural barriers to accessing health care in Rhode Island;~~

~~(2) One hospital CEO nominated from among the hospitals in Rhode Island;~~

~~(3) One physician nominated from among the primary care specialty societies in Rhode Island;~~

~~(4) One physician nominated from among the specialty physician organizations in Rhode Island;~~

~~(5) One nurse or allied health professional nominated from among their state trade organizations in Rhode Island;~~

~~(6) One practicing nursing home administrator, nominated by a long-term care provider organization in Rhode Island;~~

~~(7) One provider from among the community mental health centers in Rhode Island;~~

~~(8) One representative from among the community health centers of Rhode Island;~~

~~(9) One person from a health professional learning institution located in Rhode Island;~~

~~(10) Director of the Department of Health;~~

~~(11) Director of the department of human services or designee;~~

~~(12) CEOs of each health insurance company that administers the health insurance of ten percent (10%) or more of insured Rhode Islanders;~~

~~(13) The speaker of the house or designee;~~

~~(14) The house minority leader or designee;~~

~~(15) The president of the senate or designee;~~

~~(16) The senate minority leader or designee; and~~

~~(17) The health care advocate of the department of the attorney general.~~

SECTION 7. Section 42-14.5-1 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:

42-14.5-1. Health insurance commissioner. -- There is hereby established, within the ~~department of business regulation~~ office of health policy, an office of the health insurance commissioner. The health insurance commissioner shall be appointed by the governor, with the advice and consent of the senate. The director of the department of business regulation and the department of administration shall grant to the health insurance commissioner reasonable access to appropriate expert staff.

SECTION 8. Title 35 of the General Laws entitled "PUBLIC FINANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 1.2

OFFICE OF HEALTH POLICY

35-1.2-1. Statement of intent. – The purpose of this chapter is to establish a comprehensive health policy and management system for the state of Rhode Island that manages a data-driven planning and regulatory process; oversees health insurance practices and solvency, while reducing cost growth; monitors quality, access and community health outcomes; and ensures accountability and transparency in health care delivery and payment.

35-1.2-2. Establishment of the office of health policy. – There is hereby established within the department of administration an office of health policy. This office shall serve as the principal agency of the executive branch of state government for the implementation of a cohesive state strategy to reduce health care expenditure growth while increasing access to quality and accountable care.

In this capacity, the office shall:

(1) Develop a statewide health plan that will guide resource allocation and regulatory decision-making;

(2) Establish a health expenditure growth cap each year that will be used to guide commercial insurance rate increases;

(3) Tie health facility certificate of need decisions to the needs identified in the statewide health plan;

(4) Coordinate health care data collection and analysis within and between state departments and agencies, toward meaningful and continual use;

(5) Expedite health care delivery and payment reform to lower cost growth while ensuring quality care and outcomes;

(6) Regulate insurance practices to oversee consumer protection, provider relations, network adequacy, and insurer solvency;

(7) Encourage the universal adoption of tools such as electronic medical records and service delivery models that enhance patient outcomes; and

(8) Act as the state's primary entity to implement the commercial insurance provisions of the United States Affordable Care Act, including the utilization of efficient mechanisms to ensure ease of access to affordable insurance and federal subsidies and tax credits.

35-1.2-3. Director of management and budget. Appointment and responsibilities. – (a) Within the department of administration there shall be a director of health policy, who shall be appointed by the director of administration with the approval of the governor. The director shall be responsible to the governor and director of administration for supervising the office of health policy and for managing and providing strategic leadership and direction to the office of the health insurance commissioner, the office of healthcare delivery, and the office of health analytics and planning.

(b) The director of health policy shall be responsible to:

(1) Oversee the functions of the office of the health insurance commissioner;

(2) Coordinate and manage health data gathering, transparency and planning functions;

(3) Integrate the state's health delivery system regulatory and oversight functions into the office;

(4) Implement United States Affordable Care Act commercial insurance access and affordability provisions with accountability and efficiency; and

(5) Integrate the appropriate sections of chapter 23-17 licensing of health care facilities, as determined by the general assembly based upon recommendations of the office of health policy.

35-1.2-4. Offices and functions assigned to the office of health policy – Powers and duties. – (a) The offices and functions assigned to the office of health policy include the office of the health insurance commissioner in accordance with chapter 42-14.5; health care planning and accountability advisory council in accordance with § 23-81-3.1; and the following functions of the department of health:

(1) Certificate of need, in accordance with chapter 23-15;

(2) Hospital conversion act in accordance with § 23-17.14;

(3) Utilization review in accordance with § 23-17.12-9;

(4) Health care accessibility and quality assurance act in accordance with chapter 23-17.13; and

(5) Health care quality program in accordance with chapter 23-17.17.

(b) The offices assigned to the office of health policy shall:

(1) Exercise their respective powers and duties in accordance with their statutory authority and the general policy established by the governor or by the director acting on behalf of the governor or in accordance with the powers and authorities conferred upon the director by this chapter;

(2) Except as provided herein, no provision of this chapter or application thereof shall be construed to limit or otherwise restrict the office of the health insurance commissioner from fulfilling any statutory authority or requirement.

35-1.2-5. Office of health policy expenses. – (a) There is created a restricted receipt account for the office of health policy to be funded by application, rate review and audit fees or financial penalties paid by regulated entities. Payments from the account shall be limited to expenses directly incurred conducting related regulatory functions.

(b) All amounts deposited in the office of health policy accounts shall be exempt from the indirect cost recovery provisions of § 35-4-27.

(c) The office of health policy is authorized to receive indirect costs on federal funds to cover oversight expenses.

35-1.2-6. Appointment of employees. – (a) With the exception of the health insurance commissioner who shall be appointed in accordance with § 42-14.5-1, the director of administration, subject to the provisions of applicable state law, shall be the appointing authority for all employees of the office of health policy. The director of administration may delegate this function to such subordinate officers and employees of the office as may to him or her seem feasible or desirable.

(b) Positions and funding currently assigned to the department of health, the office of the health insurance commissioner, and other state agencies whose functions are herein being assigned to the office of health policy shall be transferred along with those functions.

35-1.2-7. Appropriations and disbursements. – The general assembly shall annually appropriate such sums as it may deem necessary for the purpose of carrying out the provisions of this chapter. The state controller is hereby authorized and directed to draw his or her orders upon the general treasurer for the payment of such sum or sums, or so much thereof as may from time

to time be required, upon receipt by him or her of proper vouchers approved by the director of the office of health policy, or his or her designee.

35-1.2-8. Rules and regulations. – The office of health policy shall be deemed an agency for purposes of § 42-35-1, et seq. of the general laws. The director shall make and promulgate such rules and regulations, and establish fee schedules not inconsistent with state law and fiscal policies and procedures as he or she deems necessary for the proper administration of this chapter and to carry out the policy and purposes thereof.

35-1.2-9. Severability. – If any provision of this chapter or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the chapter, which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are declared to be severable.

SECTION 9. This act shall take effect on July 1, 2015.

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LC004668
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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY - OFFICE OF HEALTH POLICY

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This act would create an office of health policy, within the department of administration, whose responsibility it would be to reduce the cost of health care while increasing access to quality health care.

This act would take effect on July 1, 2015.

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