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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2022

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT

Introduced By: Senators Pearson, and DiPalma

Date Introduced: June 03, 2022

Referred To: Senate Finance

It is enacted by the General Assembly as follows:

1 SECTION 1. Title 42 of the General Laws entitled "STATE AFFAIRS AND
2 GOVERNMENT" is hereby amended by adding thereto the following chapters:
3 CHAPTER 7.5
4 THE HEALTH SPENDING ACCOUNTABILITY AND TRANSPARENCY ACT
5 **42-7.5-1. Short title.**
6 This chapter shall be known and may be cited as "The Health Spending Accountability and
7 Transparency Act."
8 **42-7.5-2. Purpose.**
9 (a) The purpose of the health spending accountability and transparency act is to promote
10 accountability for health care spending by health insurers and health care providers.
11 (b) To ensure accountability for health care spending, it is necessary for agencies of the
12 executive branch, health insurers, health care providers, and other interested parties to:
13 (1) Analyze health care spending data to identify the drivers of health care spending;
14 (2) Measure the specific performance of health care entities on measures of spending,
15 efficiency, and quality;
16 (3) Adopt a health care cost growth target as a benchmark to compare the performance of
17 health care entities on measures of health care spending growth; and
18 (4) Develop actionable interventions and policies to address health care spending growth
19 while ensuring health care access, equity, and a high quality of care for patients.

42-7.5-3. Definitions.

As used in this chapter the following words and phrases shall have the following meanings:

(1) "Government entity" means agencies of the executive branch of Rhode Island government, including, but not limited to, the executive office of health and human services, the department of behavioral healthcare, developmental disabilities and hospitals and the department of administration, and the federal Centers for Medicare and Medicaid Services.

(2) "Health care entity" means an insurer or a health care provider entity organized as an accountable care organization or accountable entity under the Rhode Island Medicaid program that assumes accountability for the total or near total cost of care for a defined population.

(3) "Insurer" means all persons offering, administering, and/or insuring healthcare services, including, but not limited to:

(i) Policies of accident and sickness insurance, as defined by chapter 18 of title 27:

(ii) Nonprofit hospital or medical-service plans, as defined by chapters 19 and 20 of title 27;

(iii) Any person whose primary function is to provide diagnostic, therapeutic, or preventive services to a defined population on the basis of a periodic premium;

(iv) All domestic, foreign, or alien insurance companies, mutual associations, and organizations;

(v) Health maintenance organizations, as defined by chapter 41 of title 27;

(vi) All persons providing health benefits coverage on a self-insurance basis;

(vii) All third-party administrators described in chapter 20.7 of title 27;

(viii) All persons providing health benefit coverage under Title XIX of the Social Security Act (Medicaid) as a Medicaid managed care organization offering managed Medicaid; and

(ix) All persons providing health benefit coverage through Medicare Advantage.

(x) "Insurer" shall not include any nonprofit dental service corporation as defined in § 27-20.1-2.

(4) "Person" means any individual, corporation, company, association, partnership, limited liability company, firm, state governmental corporations, districts, and agencies, joint stock associations, trusts, and the legal successor thereof.

42-7.5-4. Health spending accountability and transparency program.

(a) The health spending accountability and transparency program ("program") is hereby created to utilize health care expenditure data collected from insurers and government entities to facilitate transparency into the causes of health care spending growth, the distributive burden of health care spending on consumers, businesses, and taxpayers, and to ensure accountability for

health care spending growth and quality performance by health care entities.

(b) The program shall be administered by the health insurance commissioner who is hereby directed to:

(1) Set and maintain an annual health care cost growth target that shall be used as a benchmark to assess the performance of health care entities on measures of health care spending growth;

(2) Convene a steering committee comprised of health care providers, health insurers, consumer advocates, businesses, and other parties with relevant expertise to meet at least quarterly and advise the health insurance commissioner on direction of the program;

(3) Use data to identify the factors that are causing increased health spending in the state, to create actionable analysis to drive changes in policy and practice, and to develop and recommend cost reduction strategies for health care entities; and

(4) Require health care entities whose annual health care spending growth exceeds the health care cost growth target to file a written explanation of the reasons for exceeding the target with the health insurance commissioner following a form and manner determined by the health insurance commissioner. The health insurance commissioner shall review and provide a written assessment of the explanation provided by the health care entity which shall be posted on the health insurance commissioner's website and submitted with the annual report to the general assembly as described under § 42-7.5-5.

42-7.5-5. Annual reports and public meetings.

(a) The health insurance commissioner shall prepare an annual report and convene a public meeting concerning health care spending and health care spending growth. The report shall be submitted to the general assembly annually on or before May 1 of each year, commencing on May 1, 2023.

(b) The report shall include, but may not be limited to, the following analyses:

(1) An analysis of the absolute value and rate of growth of total health care spending for the state as a whole;

(2) An analysis of the absolute value and rate of growth of health care spending by market, including the commercial market, which shall be inclusive of health care expenditures made by third-party insurers acting on behalf of self-insured employer groups in addition to fully insured plans, the Medicaid managed care market, and the Medicare managed care market;

(3) An analysis of health care spending growth by health care entity compared to the health care cost growth target. Health care entities shall be specifically identified in the report;

(4) An analysis of health care quality performance by health care entities based on a suite

of health care quality measures selected by the health insurance commissioner; and

(5) An analysis of the drivers of health care spending growth by service category, as well as the relative contribution of utilization and price on the rate of growth.

42-7.5-6. Regulations.

The health insurance commissioner shall promulgate all necessary and proper rules and regulations to implement this chapter.

SECTION 2. Title 42 of the General Laws entitled "STATE AFFAIRS AND GOVERNMENT" is hereby amended by adding thereto the following chapter:

CHAPTER 14.7

THE RHODE ISLAND ALL-PAYER HEALTH CARE PAYMENT REFORM ACT

42-14.7-1. Short title.

This chapter shall be known and may be cited as "The Rhode Island All-Payer Health Care Payment Reform Act."

42-14.7-2. Legislative findings, intent, and purpose.

The general assembly hereby finds and declares as follows:

(1) Health care providers are stewards of critical health care resources and deliver services that are necessary to support the health and wellbeing of Rhode Islanders and the communities in which they live.

(2) The structure and terms of health care payment significantly influences the allocation of resources within the health care system by creating a system of incentives that influence the behavior of health care providers and health care purchasers.

(3) The prevailing system of fee-for-service payment creates a financial incentive for increasing the volume of health care services and acts as a barrier to meaningful systemic transformations in health care delivery that would promote more affordable and predictable cost growth, improved financial stability for health care providers, and technical innovation in care delivery to support population health and quality excellence.

(4) The coronavirus disease 2019 public health emergency heightened the faults of the prevailing system of fee-for-service payment. The sharp reduction in service volume caused by the suspension of elective procedures, combined with increasing marginal costs borne by health care providers to institute infection control measures, necessitated the appropriation and disbursement of hundreds of millions of dollars by the State of Rhode Island and the federal government in the form of economic stabilization and revenue replacement funds for health care providers. The aggregate value of these economic stabilization and revenue replacement funds was largely distributed to hospitals and hospital systems, which account for the highest share of total health

care spending.

(5) The fragmented organization of health care purchasing activity between multiple public and private payers, acting principally through competing health insurance companies, precludes meaningful efforts to align the structure and terms of health care payment in the absence of government intervention and creates administrative burdens for health care providers.

(6) Government, as health care purchaser and regulator, possesses a unique role as a convener and facilitator of discussions between health care providers and health insurers, acting on behalf of health care purchasers, to reform the structure and terms of health care payment as a means to improve operating efficiency, improve health care quality, reduce administrative burden, and serve the public interest in healthy people and equitable health outcomes.

(7) Payment reform, defined as the restructuring of the terms of health care payment through the development and implementation of advanced value-based payment models, is necessary to achieve the goals of affordable and predictable cost growth, improved financial stability for health care providers, and technical innovation in care delivery to support population health and quality excellence.

(8) The general assembly recognizes that on April 13, 2022, Rhode Island health care leaders entered into a compact to accelerate advanced value-based payment model adoption, finding that transforming payment away from fee-for-service to a prospective budget-based model can support improved health care affordability and reorient health care delivery to focus on how best to organize health care resources to meet population needs, and improve access, equity, patient experience, and quality.

(9) The benefits of payment reform are maximized when advanced value-based payment models enjoy the participation of all payers, public and private. Rhode Island has a successful track record of all-payer health care reforms. This includes the patient-centered medical home program for primary care endorsed by the general assembly under chapter 14.6 of title 42, the ("Rhode Island All-Payer Patient-Centered Medical Home Act").

(10) It is the intent of the general assembly to endorse and support the efforts of health care providers and health insurers, acting on behalf of health care purchasers, to increase the adoption of advanced value-based payment models in Rhode Island. Furthermore, the general assembly endorses the findings and efforts articulated by health care leaders in the April 13, 2022, Compact to Accelerate Advanced Value-Based Payment Model Adoption in Rhode Island. It is the purpose of this chapter to provide policy direction and resources to support the development and implementation of all-payer advanced value-based payment models in Rhode Island.

42-14.7-3. Definitions.

1 As used in this chapter, the following terms shall have the following meanings:

2 (1) "Advanced value-based payment model" means a prospective budget-based payment
3 model with quality-linked financial implications that is defined for a specific patient population
4 and/or set of services.

5 (2) "Health insurer" means all entities licensed, or required to be licensed, in this state that
6 offer health benefit plans in Rhode Island including, but not limited to, nonprofit hospital service
7 corporations and nonprofit medical-service corporations established pursuant to chapters 19 and 20
8 of title 27, and health maintenance organizations established pursuant to chapter 41 of title 27 or as
9 defined in chapter 62 of this title 42, a fraternal benefit society or any other entity subject to state
10 insurance regulation that provides medical care on the basis of a periodic premium, paid directly
11 or through an association, trust or other intermediary, and issued, renewed, or delivered within or
12 without Rhode Island.

13 (3) "Health insurance plan" means any individual, general, blanket or group policy of
14 health, accident and sickness insurance issued by a health insurer as herein defined.

15 Health insurance plan shall not include insurance coverage providing benefits for:

16 (i) Hospital confinement indemnity;

17 (ii) Disability income;

18 (iii) Accident only;

19 (iv) Long-term care;

20 (v) Medicare supplement;

21 (vi) Limited benefit health;

22 (vii) Specified disease indemnity;

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

24 (ix) Other limited benefit policies.

25 **42-14.7-4. Promotion of all-payer health care payment reform.**

26 (a) All-payer payment reform convening and payment model development shall be
27 implemented as set forth herein.

28 (1) The health insurance commissioner and the Medicaid director shall convene an all-
29 payer payment reform working group comprised of health care providers, including hospitals,
30 ambulatory care providers, and clinicians, health insurers, businesses, consumer advocates, and
31 other parties with relevant expertise and interest in all-payer adoption of advanced value-based
32 payment models. The health insurance commissioner and the Medicaid director, in consultation
33 with the working group, shall be charged with developing the structure and terms of advanced
34 value-based payment models for use by all-payers. The health insurance commissioner and the

Medicaid director may exercise discretion in the selection and sequencing of payment model development by provider type but, at minimum, shall develop recommendations for the design of hospital global budgets for facility and employed clinician professional services and prospective payment for at least two (2) professional provider types. The health insurance commissioner and the Medicaid director may form subgroups of the working group to develop recommendations for the design of specific all-payer advanced value-based payment models.

(b) All-payer payment reform reports shall be provided as set forth herein.

(1) The health insurance commissioner and the Medicaid director, in consultation with the working group described under subsection (a) of this section, shall develop the following reports to supply information necessary to develop and implement advanced value-based payment models. These reports shall be submitted to the general assembly by the dates indicated in each subsection below as follows:

(i) By July 1, 2024, the health insurance commissioner and the Medicaid director shall complete a report examining the cost structure and financial performance of hospitals licensed in Rhode Island. The report shall examine, at minimum, hospital operating costs, fixed costs and variable costs, costs related to the provision of patient care, costs unrelated to the provision of patient care, net patient revenues, the relative prices received by hospitals from different payers, other income and operating expenses, profitability, and operating margins by payer type. The hospitals included in the report may have up to thirty (30) days to review the draft report prior to it being finalized;

(ii) By July 1, 2024, the health insurance commissioner and the Medicaid director shall complete a report examining the cost-shifting phenomenon between payers. The report shall also examine the fiscal and economic impact of changes to Medicaid reimbursement rates for hospital services; and

(iii) By January 1, 2025, the health insurance commissioner and the Medicaid director shall submit finished recommendations around payment model design for hospital global budgets for facility and employed clinician professional services and prospective payment for at least two (2) professional provider types.

(2) The health insurance commissioner and the Medicaid director shall procure necessary technical assistance and consulting services to prepare the payment model recommendations under subsection (a) of this section and the reports enumerated under subsection (b)(1) of this section.

(c) Engagement of the centers for Medicare and Medicaid services shall be undertaken as set forth herein.

(1) The health insurance commissioner, in consultation with the Medicaid director, shall

1 engage the federal Centers for Medicare and Medicaid Services to explore opportunities to secure
2 federal participation in advanced value-based payment models through the Medicare program. The
3 health insurance commissioner, for commercial and Medicare, and the Medicaid director, for
4 Medicaid, are authorized to negotiate the terms of any necessary waivers under Section 1115(A) of
5 the Social Security Act to secure federal participation in advanced value-based payment models in
6 Rhode Island.

7 **42-14.7-5. Annual reports on administration and implementation.**

8 The health insurance commissioner and the Medicaid director shall report to the general
9 assembly annually on or before March 1 of every year, commencing on March 1, 2023, on the
10 implementation of advanced value-based payment models and the work performed by the all-payer
11 payment reform working group described under § 42-14.7-4(a)(1). The annual report shall include
12 recommendations and draft legislative language for adoption by the general assembly, if necessary,
13 to ensure continued progress toward implementation of advanced value-based payment models in
14 Rhode Island.

15 **42-14.7-6. Regulations.**

16 The health insurance commissioner and the Medicaid director shall promulgate all
17 necessary and proper rules and regulations to implement this chapter.

18 SECTION 3. 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

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1 This act would establish the Health Spending Accountability and Transparency Act to
2 promote accountability for health care spending by health insurers and health care providers. This
3 act would also establish the Rhode Island All-Payer Health Care Payment Reform Act to provide
4 policy direction and resources to support the development and implementation of all-payer
5 advanced value-based payment models in Rhode Island.
6 This act would take effect upon passage.

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