2016

Legislative and Administrative Summary

HARI
Hospital Association of Rhode Island
Acknowledgements

This year’s budget and legislative session successes were a team effort between HARI staff, Nick Hemond of Capitol Communications Group, and our members.

We would like to express our sincere gratitude to the staff and executives of HARI’s individual member hospitals who were willing to dedicate their time and efforts to provide technical support and guidance to HARI staff; appear at legislative hearings to advocate and help educate legislators; and provide written materials and statements in support of HARI’s efforts.

HARI staff would also like to thank Providence College Health Management Program interns Jenna Wahl (’16) and Katelyn Lane (’18) for their hard work and dedication on the creation of this report.
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Introduction

After the 2015 legislative session ended abruptly on June 25th when leadership in both houses failed to reach agreement on several pieces of legislation, the 2016 session picked right up where the last session left off and was one of the most productive in recent years.

As of the printing of this report in early July 2016:

- Forty-six (46) health and hospital related bills have been enacted;
- another fourteen (14) bills are awaiting enactment; and
- thirty (30) bills were considered, but did not pass this session.

Please note that when this report was printed, fourteen bills had passed both houses and were eligible for enactment. However, they had not yet been transmitted by the General Assembly to the Governor for signature. When the remaining bills are enacted into law, there will be an update to this report reflecting the appropriate chapter numbers and effective dates.
Good Samaritan Overdose Prevention Act of 2016

Chapter 1
H.7003

Chapter 2
S.2002

The laws reinstated the 2012 Rhode Island law that expired in July 2015 exempting from liability and providing immunity to persons on probation and/or parole when he or she has administered an opioid antagonist to another person in order to prevent a drug overdose. Furthermore, if a person does not have access to an opioid antagonist and seeks medical attention for the person experiencing a drug overdose or the person experiencing a drug overdose seeks medical attention, they shall not be charged for possession of illegal substances. In addition, those who have administered an opioid antagonist or sought medical attention for someone experiencing a drug overdose may use this as a mitigation tool in drug arrests. Lastly, the attorney general and local law enforcement agencies are required to submit a report describing the impact of this act, including the number of instances in which local law enforcement was unable to charge an individual for drug possession because he or she administered an opioid antagonist or sought medical attention for someone experiencing a drug overdose. HARI was in support of this bill in the 2015 legislative year and continued its support at the beginning of 2016.

Effective date: January 27, 2016

Rhode Island Family Home Visiting Act

Chapter 28
H.7220

Chapter 23
S.2096

The Rhode Island Family Visiting Act directs the Department of Health (DOH) to develop and coordinate a statewide home visiting system for children and families at risk in Rhode Island. DOH is directed to work with the Rhode Island Departments of Human Services and Children, Youth and Families to identify appropriate and effective evidence-based home visiting models that would meet the needs of families with young children in need of services. Home visiting programs must be based upon models with comprehensive standards that ensure high-quality service delivery and demonstrate positive outcomes in early child development, health, and family outcomes. Additionally, a referral system shall be developed to identify potential children and/or families in need of services. Beginning in October 2016 DOH will also be
required to develop and make publically available an annual report on the components and outcomes of the State’s family home visiting program.

**Effective date:** May 23, 2016

Public Utilities Commission – Information Accessibility Service for Persons with Disabilities

*Chapter 52*

H.7014

*Chapter 45*

S.2051

Adds access to wireless telephones in the adaptive telephone equipment loan program that serves the need of Rhode Islanders who are deaf, hard-of-hearing, severely speech impaired, or who have neuromuscular impairments.

**Effective date:** June 6, 2016

Rhode Island Health Information Exchange Act of 2008 – Authorized Access

*Chapter 71*

H.7866

*Chapter 67*

S.2898

Introduced at the request of the Executive Office of Human Services (EOHHS), these laws amend the Rhode Island Health Information Exchange Act of 2008 to allow authorized individuals to access a patient’s confidential health care information from the Rhode Island Health Information Exchange, also known as Current Care. The laws specifically allow a patient, or their authorized representative, to designate a family member, practitioner, or other individual to also access the patient’s confidential health care information to aid in better coordination of the patient’s care.

Health insurers are also authorized to access a patient’s confidential health care information for the purpose of providing care management services to its members or for quality and performance measure reporting.

**Effective date:** June 6, 2016
These measures amend the collaborative pharmacy practice statute to redefine the type of advanced training and experience required for pharmacists to work in collaboration with one or more physicians for the purpose of drug therapy management for patients. The types of pharmacists eligible to engage in collaborative practice under a collaborative practice agreement with one or more physicians is redefined by the enacted legislation.

Pharmacists are redefined as those licensed pharmacists with a bachelor of science in pharmacy and either post-graduate educational training or a doctor of pharmacy degree. Post-graduate educational training is further defined as including, but not limited to, residency training, board certification, accredited professional education institution certification, or any other continuing education provider approved by the Director of Health and relevant to the proposed scope of the collaborative practice agreement.

The measures also change the review of a collaborative practice agreement by and among one or more licensed pharmacists and one or more physicians from annual to biennial.

*Effective date:*  June 13, 2016

Freedom from Prone Restraint Act

Prohibits the use of prone restraint in certain facilities licensed by the state of Rhode Island and creates a study commission to study restrain reporting requirements of such facilities. By definition, covered facilities include all health facility and hospital settings in the state with the specific exemption of any law enforcement department, the department of corrections, the training school for youth, or the forensic unit at Eleanor Slater Hospital.

HARI testified in opposition to the same bills last year and worked with the sponsors and advocates to negotiate amendments regarding concerns with training and member participation on the study commission. This year, HARI expressed concerns in testimony before both houses with respect to the narrow definition of prone restraint. With technical assistance
from Butler Hospital and the head of security at Our Lady of Fatima Hospital, HARI was able to negotiate with the sponsors and advocates language changes to the definition of prone restraint to account for emergency/security situations. As a result of successful inclusion of the amendments, HARI dropped its opposition to the bills.

The HARI agreed-to amendments include allowing the use of prone restraint in cases of immediate action before promptly turning the person face-forward and adjustment of requirements to undergo national training for providers only in cases where facilities do not have their own training that is on par or exceeds the national training.

*Effective date: June 17, 2016*

**Police Officers – Response to Mental Health/Substance Abuse Emergencies**

*Chapter 103*  
H.7259  

*Chapter 93*  
S.2401

The laws require training and guidelines for law enforcement officers on identifying and handling mental health and substance abuse emergencies. Specifically, the Commission on Standards and Training is directed to develop and provide mandatory training and instruction for law enforcement officers and handling complaints involving mental health/substance abuse emergencies, victims, witnesses or suspects with mental illness or substance use disorders. Training must comply with the certified National Council of Behavioral Health Mental Health First Aid program for law enforcement and include behavioral health practitioners as presenters. Courses shall be designed to provide information to law enforcement officers to recognize the signs and symptoms of common mental illnesses and substance use disorders, de-escalate crisis situations safely, and initiate timely referral to mental health and substance abuse resources available in the community. Such training shall be included in all the programs for recruits and in-service trainees, as well as all police academies operating or certified by the Commission on Standards and Training in the state.

*Effective date: June 17, 2016*
Insurance – Off-label Uses of Prescription Drugs

*Chapter 105*  
H.7512 SUB A

*Chapter 95*  
S.2499 SUB B

Introduced at the request of the Rhode Island Attorney General, these measures provide Rhode Islanders expanded coverage for experimental uses of prescription drugs by requiring insurers to cover “off-label” use for drugs to treat cancer or a disabling or life-threatening chronic disease provided the drug is approved for another use by the Federal Food and Drug Administration and there is peer-reviewed medical literature to back its use for the patient’s condition.

In Rhode Island, the use of off-label medication to treat cancer has been required of insurance companies since 1994. These new amendments to the original 1994 law allow expanded access and insurance coverage for off-label uses for patients with other disabling or life-threatening chronic diseases.

**Effective date:** January 1, 2017

Behavioral Health Care – Certified Recovery Housing Facilities and Programs

*Chapter 138*  
H.8056 SUB A

*Chapter 129*  
S.2579 SUB B

These acts empower the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) to certify recovery housing facilities and programs for residential substance abuse treatment. BHDDH is authorized to develop guidelines for the certification of recovery housing, which should include adherence to National Alliance for Recovery Residences guidelines. Additionally, all referrals from state agencies or facilities shall only be to certified recovery houses. Only BHDDH certified recovery housing facilities will be eligible to receive state funding for the delivery of services.

**Effective date:** June 24, 2016
Office of Health Insurance Commissioner – Rate Review

*Chapter 156*  
H.7510 SUB A as amended

*Chapter 145*  
S.2209 SUB A as amended

These chapters amend the duties of the Office of Health Insurance Commissioner (OHIC) with regard to commercial health insurance rate review. The new laws create a uniform rate review procedure for rates proposed to be changed or rating formulas proposed to be used by nonprofit hospital service corporations, nonprofit medical services corporations, and the catastrophic health insurance plan requiring public hearings or public meetings with the applicant bearing the reasonable expenses of the filing. The current public hearing requirement is amended to apply to only those insurers in the direct pay market that cover 10,000 lives. Alternatively, a hearing would be required for insurers requesting a ten percent (10%) or more overall average rate increase. These changes do not limit the appeal rights of any person or entity that had the right to appeal a final decision of OHIC under current law.

Effective date: January 1, 2017  
Sunset: January 1, 2021

Medical Assistance – Long Term Care Uncompensated Care

*Chapter 158*  
H.7773 SUB A

*Chapter 150*  
S.2532 SUB A

These acts define “long-term care provider (LTC provider)” relative to applications for Medicaid benefits. The amendments in the acts also allow for the release of information from the Secretary of EOHHS to LTC providers and also provide that after 90 days of uncompensated care of an LTC patient, the provider may apply to the state for relief.

Prior to this law, LTC providers provided care to patients with pending Medicaid applications without compensation until the application is approved. The new statutes now allow LTC providers to request payment in full from EOHHS for care provided when a patient’s application has been pending for 90 days or longer. Additionally, LTC providers will receive such payment as if the application were approved and payments shall continue to the provider from EOHHS until a final decision is made on the patient’s Medicaid application. Should the application be denied, the state does not have any right of recovery for payments made during the period of
determination. However, if the application is approved, the state has the ability to offset the interim payments made to an LTC provider.

**Effective date:** June 27, 2016

## Waiver of Medical Record Fees for Veterans

**Chapter 162**

H.8319

**Chapter 146**

S.2296 SUB A

These measures require all health care providers to provide veterans with copies of their medical records free of charge when the records are being used to apply for benefits. Specifically, veterans are not to be charged any copying, postage, retrieval or processing fees when the request is made for facilitation of an application for post-service benefits. The purpose is to assist returning veterans and their families in obtaining the services they may need to help in the transition back to civilian life. Additionally, health care providers are also under an obligation to furnish a requested health record to a veteran by mail or electronically within thirty (30) days of the request.

**Effective date:** June 27, 2016

## Insurance – Pricing and Pharmacy Benefit Manager Oversight

**Chapter 168**

H.7438 SUB A

**Chapter 166**

S. 2467 SUB A

Provides that pharmacy benefit manager (PBM) contracts with pharmacies should include updated pricing information on a maximum allowable cost (MAC) list. The MAC is the maximum amount that a PBM will reimburse toward the cost of a drug. PBMs are further required to update their pricing information on the MAC list at least every ten (10) calendar days and include such requirement in their contracts with pharmacies. The measures also detail the procedure PBMs must develop and maintain to eliminate or modify drugs on their MAC list and provides an appeals process for pharmacies. Oversight of PBMs and their adherence to the new statutes is placed within the authority of DOH.
These laws were sent to the Governor, but were not vetoed or affirmatively signed into law. Pursuant to Rhode Island law, they became effective without the Governor’s signature on June 19, 2016.

*Effective date: September 30, 2016*

**Business and Professions – Licensed Chemical Dependency Professionals**

*Chapter 187*  
H.7130  
Chapter 183  
S.2948

These chapters allow licensed chemical dependency professionals with the proper training to utilize a treatment known as auricular acudetox in their practice. Auricular acudetox involves the insertion of disposable needles in consistent, predetermined locations on the ear, in accordance with the protocol established by the National Acupuncture Detoxification Association. A procedure for licensure and regulation of the practice under the general supervision of a licensed acupuncturist is also set forth in the new laws.

*Effective date: January 1, 2017*

**Telemedicine Coverage and Reimbursement**

*Chapter 188*  
H.7160 SUB B  
Chapter 177  
S.2577 SUB A

These chapters require insurers to include coverage for telemedicine services on plans or contracts issued, renewed, or delivered on or after *January 1, 2018*. “Telemedicine” is defined in the new laws as a licensed health care provider delivering health care services through two-way communication to assess, diagnose, and treat a patient at a different site than that of the provider. Health insurers are required to provide telemedicine coverage and cannot deny a patient coverage for services based only on the fact that services were provided by telemedicine. Insurers are permitted to apply co-payments, deductibles, and co-insurance to services provided via telemedicine.
A priority bill for HARI this session, the association joined with the Rhode Island Medical Society (RIMS) to strongly support the measures with letters and testimony before the House and Senate. At the request of the House sponsor of the legislation, HARI staff also joined with RIMS, RI AARP, representatives of insurers and other providers in discussions over several months in an attempt to find common agreement on coverage and payment terms for telemedicine and telehealth services.

With its enactment, Rhode Island now joins most of the nation, including most recently Connecticut, in recognizing the use of telemedicine technology as an effective tool in providing patients high quality health care, at a lower cost.

Copies of HARI’s letters of support for these measures can be found at the end of this report.

**Effective date:** June 28, 2016

**Mental Illness and Substance Abuse – Comprehensive Discharge Planning – The Alexander Perry and Brandon Goldner Act**

**Chapter 189**
H.7616 SUB A

**Chapter 172**
S.2356 SUB A as amended

These acts aim to ensure that those who are treated at hospitals, freestanding emergency rooms, clinics and urgent care facilities with a substance abuse disorder receive the appropriate care, intervention by recovery coaches, and follow-up care they need to address their addiction. It would require facilities to submit to DOH by January 1, 2017 its comprehensive discharge plan and recovery plan for patients treated for substance use disorders. These measures further require facilities to attempt to contact a patient’s emergency contact and recovery coach access before discharge. HARI worked with the sponsors and a coalition of providers on amendments to ensure a patient’s consent is obtained where possible, and documented in the medal record when refused.

Insurers are also required to cover medication-assisted addiction treatment including methadone, buprenorphine and naltrexone. Facilities providing the first course of such treatment are also required to continue providing such treatment until the patient is able to be transferred to an inpatient or outpatient treatment provider.
The measures also require patients to receive real-time information about the availability of follow-up treatment, building upon Chapters 108 and 109 of 2014 which required facilities to give patients information about where they could get help upon their discharge. DOH and BHDDH are required to develop a real-time patient services database showing providers the availability of clinically appropriate inpatient and outpatient services and make it accessible to providers by **January 1, 2018**.

DOH and BHDDH are further tasked with developing and disseminating to providers, guidelines and regulations by **January 1, 2017** addressing:

- A regulatory standard for the early introduction of a recovery coach during the pre-admission and/or admission process for patients with substance use disorders, opioid overdose, or chronic addiction;
- Substance abuse evaluation standards for patients with substance use disorders, opioid overdose, or chronic addiction;
- Pre-admission, admission, and discharge regulatory standards, a recovery plan and voluntary transition process for patients with substance use disorders, opioid overdose, or chronic addiction;
- Best practices standards for health care clinics, urgent care centers, and emergency diversion facilities regarding protocols for patient screening, transfer and referral to clinically appropriate inpatient and outpatient services; and
- Regulations for patients presenting to hospitals and freestanding emergency care facilities with indication of a substance use disorder, opioid overdose, or chronic addiction to ensure prompt, voluntary access to clinically appropriate inpatient and outpatient services.

HARI supported the concept and the package of bills aimed at Rhode Island’s opioid overdose crisis that included these measures. HARI submitted letters and testimony in support before both houses, while working with the sponsors and a coalition of providers on amendments to address member concerns.

Copies of HARI’s letters of support for these measures can be found at the end of this report.

**Effective date:**  **June 28, 2016**
Business and Professions – Nursing Assistants

Chapter 191
H.7637

Chapter 182
S.2875

These measures exempt students from registration and supervision requirements of the registration of nursing assistants so long as they are duly enrolled in a bachelor of science in nursing program, an associate degree in nursing program, an accredited licensed practical nurse program, or other registered nurse course of study. Eligible students must also have completed two (2) clinical courses and there is supervision in place of their work by a registered nurse.

Effective date: June 28, 2016

Insurance – Coverage for Opioid Antagonists

Chapter 192
H.7710 SUB A

Chapter 175
S.2460 SUB A as amended

The measures require all health insurers who provide prescription drug coverage to provide coverage for at least one generic opioid antagonist and device. Prior authorization may still be required by insurers for non-generic forms of opioid antagonists and devices. This coverage requirement shall apply to all plans issued for delivery, amended, or renewed on or after January 1, 2017.

The bills originally received opposition from health insurers arguing that such a mandate would increase the prices of these drugs, and that many insurers already cover opioid antagonists in their health plans. The OHIC also expressed concerns that the measures might be considered a mandate under Federal law. However, the measures passed and were enacted into law as part of a package of bills aimed at addressing Rhode Island’s opioid overdose crisis.

Copies of HARI’s letters of support for these measures can be found at the end of this report.

Effective date: January 1, 2017
Insurance – Coverage for Biological/Interchangeable Biological Products

Chapter 193
H.7816 SUB A as amended

Chapter 178
S.2755 SUB B as amended

Adds biological products and interchangeable biological products to the medications pharmacies may dispense, and regulate the procedures for dispensing and substitution. The acts also define the procedures pharmacists must for follow-up communications with the prescriber within five (5) days of dispensing, including entry of data into the patient’s electronic medical record.

Effective date: June 28, 2016

Prescription Drug Monitoring Program – Designee Access

Chapter 194
H.7847

(not transmitted to Governor)

S.2897

These laws authorize any vendor, agent, contractor, or designee who operates an electronic medical record (EMR) or clinical management system to have access to the prescription drug monitoring program (PDMP). The intent is to improve health care by addressing the potential of over-prescribing and over-dispensing of opioids and other pain medications. Maintained by the Department of Health, the PDMP tracks the dispensing of all prescriptions in Rhode Island. Access to the PDMP is controlled by statute, and these changes add additional designees who can access the PDMP.

To date, only the House version of the bill has been transmitted to the Governor for signature and enacted into law.

Effective date: June 28, 2016
Uniform Controlled Substances Act – Electronic Transmission of Schedule V Prescriptions

**Chapter 195**
H.7849

These measures add Schedule V prescriptions to the categories of prescriptions that can be transmitted electronically to pharmacies. Through these amendments to the Rhode Island Uniform Controlled Substances Act, DOH is expected to amend its regulations regarding electronic transmission of Schedule II, III, IV and V prescriptions accordingly.

**Effective date:** June 28, 2016

Insurance – Synchronization of Prescriptions and Coverage for Less than 30 Day Supply

**Chapter 196**
H.8022 SUB A

These laws direct health insurers to provide prescription drug coverage for prescriptions of less than a thirty (30) day supply for the purpose of synchronizing the patient’s medications for treatment of chronic conditions. Additionally, the statute specifies specific factors that the covered medications must meet in order to qualify for appropriate synchronization of prescriptions. Any covered prescription on Schedules II through V of the Uniform Controlled Substances Act are specifically exempt from the statute. Patients are also limited to the filling of a short term prescription (less than 30 days’ supply) once a year for the purpose of medication synchronization.

**Effective date:** January 1, 2017
These measures require practitioners to register with the state prescription drug monitoring program (PDMP) as a condition of initial registration or renewal of such practitioner’s authority to prescribe controlled substances. DOH is required to promulgate regulations to appropriate training in best prescribing practices needed for license renewal, by **January 1, 2017**. The new laws also detail guidelines for prescribing practitioners for monitoring the PDMP and prescribing guidelines for refilling or initiating opioid therapy. Specific maximum opioid prescribing limits for acute pain management are also imposed and DOH is directed to promulgate regulations for prescribing practitioners on appropriate limits of opioid use in acute pain management.

Pharmacies are also required to transmit prescription information to the PDMP within one business day of the dispensing of an opioid prescription. Pharmacists must also include in patient education information about the proper disposal of unused or unwanted medications.

These new laws were enacted into law as part of a package of bills aimed at addressing Rhode Island’s opioid overdose crisis.

**Effective date:** June 28, 2016

The new laws seek to improve the usefulness of the prescription drug monitoring program (PDMP) by adding analytical functions, requiring program updates at least weekly, and incorporating data from similar databases in other states, where available.

DOH is directed to promulgate regulations that include may analytical enhancements such as consolidation of data from multiple pharmacies for each patient; analysis to alert of unusual or aberrant prescription patterns by patient or prescriber; and identification of patterns or
linkages among prescribers, patients or pharmacies. DOH will also be required to submit an interim report on the status of PDMP updates to the General Assembly by October 1, 2016 with annual summary reports required by February 1st of each year.

To date, only the House version of the bill has been transmitted to the Governor for signature and enacted into law.

*Effective date: June 28, 2016*
Legislation Passed and Awaiting Enactment
As of the date of the printing of this report, the following bills have passed both houses of the General Assembly in concurrence but not yet been transmitted to the Governor for signature. The descriptions and effective dates noted below are done in anticipation of enactment. At this time, there is no indication of an intended veto of the legislation below.

### Board of Medical Licensure and Discipline – Due Process Provisions

H.7818  
S.2468

This act would add certain procedural requirements relating to the issuance of subpoenas and the inspection of a licensee's office to the disciplinary and oversight powers of the board of medical licensure and discipline.

**Effective date:**  Immediate upon enactment

### Business and Professions – Non-Competition Agreements

H.7586 SUB A  
S.2578 SUB A

These acts would render restrictive covenants in employment agreements with physicians void and unenforceable except where restrictive covenants and non-compete clauses are in the purchase and sale agreement of a physician's practice and they are for a period of no more than five (5) years.

Similar bills from prior sessions were opposed by HARI and did not advance. However, a March 2016 Superior Court decision by Justice Silverstein struck down the enforcement of a similar restrictive covenant in the medical field. The court concluded that even in the absence of a Rhode Island statute similar to the Massachusetts one prohibiting the use of such covenants; the public interest of allowing Rhode Islanders to “retain health care service providers of their choice” outweighed any benefit of a restrictive covenant to the practice. (Medicine and Long Term Care Associates, LLC v. Khurshid, at p. 5).
Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act – PTSD and Hospice Care

H.7142 S.2115

These measures would add post-traumatic stress disorder (PTSD) to the list of defined debilitating conditions that may be treated with medical marijuana.

The bill would also accelerate the issuance of an approved medical marijuana use application if the patient is eligible for hospice care. It would require DOH to issue a registry identification card to the qualifying patient and primary caregivers named in the patient’s application within 72 hours of receipt of the completed application. DOH is also directed to waive the registration fee for hospice care patients or their caregivers.

Effective date: Immediate upon enactment

Freestanding Emergency Care Facilities – Regulation and CON Requirement

H.7500 SUB A S.2696 as amended

This year, Rhode Island saw the entry into the healthcare marketplace of freestanding emergency rooms. However, because of a statutory change in the 1980’s that was not later amended, freestanding emergency rooms were only subject to the less-rigorous licensure standards, instead of the state’s Certificate of Need (CON) process. HARI joined with a large coalition of providers to express concerns about licensure applications before the Health Services Council and made amending the statute to subject new freestanding emergency rooms (ERs) a priority. HARI and a coalition of provider groups also strongly supported these measures before the House and Senate.
The measures add the definition of “freestanding emergency care facility”, taken from existing DOH regulations, to the health care facility licensure statute making freestanding ERs subject to the same regulations within the statute. They also add additional requirements that currently apply to hospitals who provide emergency care: financial disclosure, charity care, adverse event reporting, pre-facility exposure reporting for emergency medical technicians, restocking requirements for emergency medical services vehicles, and interpreter services. These changes impose a level playing field by specifically excluding freestanding ERs from the organized ambulatory care facility (OACF) exemption from obtaining a separate license for each subsequent location.

Upon enactment, currently licensed freestanding ERs will be subject to the above requirements. Additionally, all future freestanding ER applications to the state will be subject to the Certificate of Need process. These measures are expected to be signed into law once transmitted to the Governor for her signature.

Copies of HARI’s letters of support can be found at the end of this report.

**Effective date:** Immediate upon enactment

**Health Care Facilities - Circulating Nurses**

H.7448 SUB A  S.2469 SUB A as amended

These measures would require each hospital and ambulatory surgery facility to adopt policies and procedures to have a minimum of one perioperative circulating nurse physically present in each operating room for the duration of each surgical procedure.

The original legislation defined perioperative nurse as one who must be present during each surgical or other procedure. HARI opposed the bill as written before both house due to the requirement of a perioperative nurse for every procedure and not just within an operating room. After negotiations with the proponents and sponsors of the bill, the language was amended to specify that a perioperative circulating nurse’s presence be required for surgical procedures only. Once the bill language was amended to reflect HARI concerns, the bill passed both houses of the General Assembly and is expected to be signed by the Governor when transmitted for signature.

Copies of HARI’s letters opposing the original bill as written can be found at the end of this report.

**Effective date:** October 1, 2016 (once enacted)
Health Care Facilities – Extension of Moratorium on Nursing Facility Licensure

S.2457

This act would extend the current moratorium on nursing facilities and prohibit the licensing of any new facilities through July 1, 2019. Although this bill did not have a House companion that also passed, the Senate bill passed both houses in concurrence before the end of session.

*Effective date:* Immediate upon enactment

Insurance – Medical Billing Innovation Act of 2016

H.7786 SUB A S.2828 SUB A as amended

This act would authorize OHIC to provide a report to the General Assembly by January 1, 2017 with recommendations for establishing guidelines and regulations for systems that would give patients electronic access to their health insurance claims information and outstanding obligations to for medical services received, pursuant to Federal law.

*Effective date:* Immediate upon enactment

Insurance – 30 Day Notice Requirement Prior to Coverage Changes for Prescription Drugs

S.2294 SUB A

This act would require all health insurers to give thirty (30) days' notice to authorized prescribers by established communication methods and by updating available references and web-based publications before making any change in preferred or tiered cost sharing status of a
covered drug. Any drug deemed unsafe by those entities or by the Federal Food and Drug Administration may be removed immediately without prior notice. Although this bill did not have a House companion that also passed, the Senate bill passed both houses in concurrence before the end of session.

*Effective date: January 1, 2017 (once enacted)*
Enacted Resolutions
Special Legislative Study Commission – Health Literacy

Resolution 239 S.2594 SUB A as amended

Creates a special legislative commission to make a comprehensive study on the topic of health literacy in order to develop a strategic plan that would maximize opportunities for collaboration and programs that would assist Rhode Islanders’ ability to navigate the health care system and improve health outcomes. The Commission shall consist of seventeen (17) members and include: three (3) members of the state Senate; three (3) consumer advocates; one representative of higher education; the Secretary of the Executive Office of Health and Human Services; the Director of the Rhode Island Community Action Association; the Director of the Rhode Island Department of Health; the Director of the Office of the Health Insurance Commissioner; the Director of the Rhode Island Division of Elderly Affairs; the Commissioner of the Rhode Island Department of Education; the President of the HARI; the Executive Director of Health Source Rhode Island; and two (2) culturally and linguistically competent professionals. The Commission is tasked with submitting a report on its findings and recommendations to the Governor and the President of the Senate no later than February 1, 2017. The Commission will then expire on July 1, 2017.

Effective date: May 17, 2016

Special Legislative Study Commission – Rare Diseases – Extending Expiration Date

Resolution 249 H.8149

Created by Resolution 408 of 2015, this special legislative commission was constituted to make a comprehensive study and recommendations on coordinating efforts of state resources, private entities, and social services in order to provide efficient care for Rhode Islanders living with rare disease and supports for their caregivers. The Commission consists of 9 members and include: 3 Representatives of the House of Representatives; the Director of HEALTH; the President of HARI; an individual diagnosed with a rare disease and a caregiver; the Associate Dean for Public Health and Policy at the Alpert Medical School at Brown University, and the President of the Rhode Island Public Health Association. The Commission was tasked with
submitting a report on its findings and recommendations to the House of Representatives by March 26, 2016.

However, the Commission concluded in its March report that its work should continue. The current resolution permanently removes the Commission’s June 24, 2016 expiration date.

*Effective date:* May 24, 2016
Legislation Considered But Not Enacted
Access to Abuse-Deterrent Pain Medications

H.7163 SUB A
H.7617
S.2461 SUB A

These bills sought to require all health insurance plans to cover abuse-deterrent drug forms of opioid analgesics without significantly increasing a patient’s responsibility of payment via cost-sharing or requiring prior authorization. As written, insurance companies cannot require any form of prior authorization or utilization review before providing the abuse deterrent opioid analgesics. Insurers strongly opposed the bills arguing before both houses that there is no significant research demonstrating that opioid analgesics with abuse-deterrent properties are successful in preventing addition and overdoses, and these types of opioids are much more expensive. Insurers also feared that a mandate to cover such opioids would result in cost and rate increases. OHIC stated in hearings that it would be working with the Federal government to determine whether the legislation was indeed a mandate. HARI, the Rhode Island Medical Society (RIMS), and a coalition of providers and patients again strongly supported the bills before both houses.

Before the end of session, the bills were amended to instead require: (1) health care providers and insurers to support clinical practices and research promoting the use of abuse deterrent opioid analgesics approved by the FDA; and (2) insurers to include one or more abuse deterrent formulations on the lowest cost prescription drug co-payment tiers to ease access.

The Senate bill passed in the last days of session, but the House sponsor pulled the bills back from a floor vote voicing concern that the amendments would not achieve the bills’ original intended effect. As a result, both bills were held in the House Corporations committee and did not progress before the end of session.

Copies of HARI’s letters in support can be found at the end of this report.

Hospital Leadership Compensation Limits

H.7502
S.2559

These bills would cap certain hospital employees’ compensation at a rate not exceeding one hundred ten percent (110%) of the northeast regional average for comparable personnel at comparable hospitals; these calculation is based on the hospital’s annual collected revenue and determined by the director of the department of health. These measures would not apply to
any person who is a licensed health care professional, such as physicians and nurses. Both bills were held in committee for further study.

HARI opposes these bills every year they are introduced. Copies of HARI’s letters of opposition are at the end of this report.

**Insurance – Coverage for Residential Inpatient Mental Health or Substance Abuse Treatment**

H.7625 SUB A  S.2510

These bills, introduced at the request of the Rhode Island Attorney General, would require insurers to cover at least ninety days of residential or inpatient services for mental health and/or substance use disorders for American Society of Addiction Medicine levels of care 3.1 and 3.3. HARI joined with RIMS, the Substance Use and Mental Health Leadership Council, and various other mental health providers to support this bill with testimony before both houses. Health insurers strongly opposed the bills as having the potential to increase premium costs.

The House version of the bill was later amended to require insurers to not deny continued residential or inpatient treatment coverage if the patient is currently in residential services for a mental health and/or substance abuse disorder and the provider of treatment has recommended continued residential treatment. The amended House bill passed its chamber, but was held in the Senate committee with the companion bill.

**Insurance – Credentialing of Health Care Providers**

H.7709  S.2576 SUB A as amended

These bills, a priority of the Rhode Island Medical Society, seek to require a health care entity or health plan to issue a decision regarding the credentialing of a health care provider within twenty (20) days of receiving a complete credentialing application and would establish the effective date for billing privileges for health care providers as the later of the date of the receipt of the complete credentialing application, or the date the health care provider is licensed by DOH.

An appeals process would be established for providers and a deadline for health plan action within ninety (90) days was set forth in the House bill. However, the Senate bill was amended
to provide for enforcement by OHIC and change the effective date from immediate to January 1, 2017.

Although the Senate version of the bill passed the Senate, the two bills’ differences could not be reconciled among the parties and both bills were held in the House Corporations committee.

**Insurance – Prohibition of Collection of Patient Cost Sharing for Mental Health/Substance Abuse Treatment**

H.7932  S.2501

A HARI priority this session, these bills address coinsurance by prohibiting insurers from using coinsurance to calculate and collect additional funds from patients, including mental health and substance abuse disorder patients. Additionally, the bills would preclude insurers from subjecting mental health and substance abuse disorder to any plan cost-sharing, including, but not limited to co-payments and deductibles.

HARI strongly supported this bill with both letters and testimony before the House Corporations and Senate Health and Human Services Committees. HARI sighted OHIC’s Administration Simplification Task Force’s 2015 findings that providers have difficulty collecting coinsurance as it is often not known at the point of service. Additionally, the task force found that patients, specifically mental health substance use patients, were avoiding care because they could not afford to pay the coinsurance payments required for services.

The Rhode Island Medical Society, the Substance Use and Mental Health Leadership Council, and various other mental health providers and patients all joined together with HARI to support the bill’s elimination of co-payments, deductibles and coinsurance for mental health and substance abuse disorder services before both houses.

Various health insurers and pharmacy benefit managers strongly opposed the bill, highlighting the need for such payment methods to contain health care costs. The insurers argued that the coinsurance would be shifted to a patient’s premium and deductible. OHIC also expressed concern about the potential impact to tiered plans available on the health insurance market. After a strong effort to work out compromise language, the bills unfortunately were held in their respective committees at the end of session.

Copies of HARI’s letters of support for the bills are attached at the end of this report.
Insurance – Surprise Bills for Medical Services

H.8004 S.2462 SUB A

These bills would grant OHIC the authority to create a dispute resolution process for emergency services and surprise bills for medical services performed by nonparticipating, or out-of-network, health care providers and reject any dispute resolution process already used by private parties. It would also include the authority to establish an independent dispute resolution entity made up of licensed physicians. Furthermore, the bills seek to prohibit health insurers from charging a patient more than in-network charges for an emergency visit at an out-of-network provider. Insurers would be required to pay the out-of-network provider the greatest of: (1) the in-network payment; (2) the usual, customary and reasonable rate of services; or (3) the amount Medicare would reimburse for services.

Providers could submit a dispute regarding the payment it received for emergency services from an insurer to the independent dispute resolution entity and receive a decision within thirty (30) days. In regards to surprise billing, the insurer will only need to pay the in-network charges it would normally pay for services to the out-of-network provider. The same current resolution process utilized with emergency services provided by an out-of-network provider will be used for surprise billing.

The Senate version was amended and passed near the end of the session, but both bills were held for further study in the House Corporations committee.

Interstate Medical Licensure Compact

H.7771 S.2497

These bills, supported by the Rhode Island Medical Society, seek to establish Rhode Island’s membership in the Interstate Medical Licensure Compact. The language details the procedure to be followed in order to allow physicians to become licensed in multiple states, while ensuring the safety of patients. The intent of the bills is to strengthen access to health care for all patients. HARI provided testimony before both houses in support of this measure; but the bills were held in their respective committees at the end of session.
Meaningful Access to Provider Directories

H.7474

Primarily supported by the Rhode Island Medical Society, these bills would require health insurers to maintain accurate and up-to-date directories of all in-network providers, and to provide that information to plan enrollees. The bills were opposed by health insurers on the basis of cost of maintenance. HARI joined with several other provider groups to testify in support of the bills and stressed the need for individuals to be able to easily determine which providers are within their plan’s networks to make more informed health care decisions. The bills were both held in their respective committees for further study.

Nurses – Enhanced Licensure Compact

H.8077

This bill seeks to improve and strengthen the current Nurse Licensure Compact (NLC), first enacted by Rhode Island in 2008. The NLC is an agreement with twenty-four (24) other states to standardize nurse licensure and enable nurses to cross state borders without the need to relicense in each state.

The current NLC would be improved through enhanced uniform licensure requirements, criminal background checks, disciplinary reporting, dispute resolution, and the establishment of an interstate governing commission with rulemaking authority. HARI supported the bill with written testimony before House Corporations committee. The bill was held for further study and did not progress this session.

A copy of HARI’s letter of support can be found at the end of this report.
Nurses - Mandated Staffing Ratios

H.7863  S.2695

Introduced again this year at the request of labor unions representing nurses, these bills would establish mandatory nurse to patient ratios for specified units of every hospital within Rhode Island. In addition, all health care facilities would be required to use a patient acuity system to determine whether the nurse staffing ratios in particular units should be lower than the bills’ minimum ratios. The bills also included civil penalties and a clause that staffing to meet ratios shall not result in understaffing of reductions of other portions of a hospital’s healthcare workforce.

This legislative push from the labor unions mirrors efforts undertaken in other states both legislatively and at the collective bargaining table, in recent years. HARI President, Mike Souza testified in opposition before both houses and was joined by nurse managers from Women and Infants’ Hospital, Our Lady of Fatima Hospital, and Westerly Hospital. Additional written testimony was submitted by CharterCare Health Partners and Westerly Hospital. Both bills remained in their respective committees at the end of session.

A copy of the testimony of HARI President, Mike Souza, opposing the bill can be found at the end of this report.

Nurses – Regulation of Agency/Temporary Nurse Hiring by Hospitals

H.7880  S.2210

Introduced at the request of SEIU, these bills seek to regulate how hospitals hire and utilize non-Rhode Island licensed temporary or agency nurses. Hospitals would be restricted from hiring temporary or agency nurses without first exhausting all reasonable efforts to fill with their own nursing staff or temporary RI licensed nurses. The bill includes specific reporting requirements to the Department of Health and the Department of Labor and Training about the name and state of licensure of any out of state licensed nurse employed by a Rhode Island licensed hospital. HARI strongly opposed the bills before both houses.

Mike Souza and HARI staff were joined by representatives from the Organization of Nurse Leaders of Massachusetts, Rhode Island, New Hampshire and Connecticut (ONL); Care New
England, and Westerly Hospital in testifying against the bills before both houses. Written testimony was also submitted in opposition on behalf of HARI, ONL, Westerly Hospital, Our Lady of Fatima Hospital and CharterCare Health Partners. Both bills were held in their respective committees for further study at the end of session.

Copies of Mike Souza’s testimony and HARI’s letters in opposition can be found at the end of this report.

**Pharmaceuticals – Creation of State Critical Drug List and Manufacturer Financial Disclosures**

H.7839  S.2560

These bills were submitted on behalf of the Rhode Island Attorney General. They seek to make drugs and their prices more transparent by requiring the EOHHS to create a critical prescription drug list and financial disclosure of those drugs on the list by drug manufacturers. Factors for EOHHS to consider when creating this drug list are the current cost of the drug, utilization of the drug, and the potential impact of the drug’s cost on statewide initiatives and achievements. Both bills were held for further study in their respective committees.

**Prescription Drug Monitoring Program – Access by Law Enforcement**

H.7518  S.2713

These bills, introduced at the request of the Rhode Island Attorney General, would remove the requirement that information contained in the prescription drug monitoring database (PDMP) maintained by DOH be provided to law enforcement authorities only pursuant to a valid search warrant, and would instead permit disclosure of said information to such authorities if in connection with a bona fide specific investigation. The PDMP contains information on almost all scheduled drugs prescribed in the state by a health care provider. Currently, Rhode Island is one of eighteen (18) states that require law enforcement agencies to obtain a warrant before accessing records within the PDMP.

Concerned about the potential for warrantless release of the sensitive information on the PDMP, HARI joined with the Rhode Island Medical Society, the Rhode Island Pharmacists...
Association, the Substance Use and Mental Health Leadership Council of Rhode Island, the Rhode Island Dental Association and several other provider groups to oppose the bill in the Senate. The bills did not progress to the floor of either house before the end of session.

A copy of the coalition letter in opposition coordinated by RIMS can be found at the end of this report.

The Rhode Island Terminally Ill Patients’ Right to Try Act of 2016

H.7156

This legislation would create the Rhode Island Terminally Ill Patient’s Right to Try Act of 2016, which establishes the conditions for the use of experimental treatments for terminally ill patients. Patients with a terminal illness would have access to an investigational drug, biological product, or device with written informed consent attested to by the patient’s physician and a witness. Any access granted to an investigational drug, product or device is not required to be covered by insurance and all expenses are the liability of the patient, but not the patient’s estate. Any health care provider who recommends a terminally ill patient’s access to an investigational drug, product or device is immune from disciplinary liability.

The bill was introduced in the 2015 session, but did not move in either house. This year, the bill passed the House, but was held in the Senate Health and Human Services committee.

Transparency – Hospital Charges and Payroll Reporting

S.2207 SUB A

The bill seeks to amend Chapter 366 of 2014 implementing transparency provisions. Chapter 366 of 2014 required DOH to collect from hospitals the twenty-five (25) most common inpatient and twenty-five (25) most common outpatient procedures and the average charge and range of charges for each. DOH is then required to make the lists available to the public on its website. The intent was to promote public awareness of healthcare costs and encourage consumer engagement in their care.

The bill’s original language sought to require hospitals to add to the transparency provisions a public reporting of the salaries and benefits of the top five highest paid hospital employees.
Additionally, hospitals would further be required to provide written estimates to patients within two (2) business days of the request.

HARI testified in opposition of the bill’s salary and benefit and reporting requirement before the committee. The bill was amended to drop the salary reporting requirements. The bill passed the Senate, and was referred to the House where it remains in committee.

A copy of HARI’s letter in opposition can be found at the end of this report.

**Utilization Review Act**

H.7708 S.3013 SUB A

These bills would, on January 1, 2017, transfer Utilization Review (UR) authority from the DOH to OHIC. The intent is to place the insurance oversight of UR into the agency that regulated health insurers – OHIC.

In addition to removing UR from DOH, the Senate bill would make changes to the state’s Health Care Accessibility and Quality Assurance Act and the Health Plan Modification Act to comply with the Federal Affordable Care Act to reflect such transfer of functions between agencies. However, the House bill sought instead to add a Health Benefit Plan Network Access and Adequacy Act amending the OHIC rate review process for health insurers and adding criteria for health plan network adequacy evaluation and enforcement.

HARI supported the streamlining of the UR process, but expressed concerns with the move of UR from DOH to OHIC in written testimony before the House committee. The Senate version of this legislation did pass the Senate, but the House version was held in the Corporations committee.

A copy of HARI’s letter of support with concern can be found at the end of this report.
Fiscal Year 2017
Enacted
State Budget
Chapter 142
H 7454 SUB A as amended

Enacted at the end of the legislative session, General Assembly approved a FY 2017 state budget that realizes a $50 million improvement with the restoration of Upper Payment Limit (UPL) and disproportionate share program (DSH) payments in state fiscal years 2016 and 2017 ($15 million for FY 2016 and $35 million for FY 2017) – a significant improvement from the Governor’s original proposed budget. Incentive Program for hospitals and rate increases remain in the budget.

Article 7 – Health and Human Services

Section 2 – Medicaid rates

- Hospital Rate increase for Medicaid fee for service (per revenue estimating conference - inpatient (3%) and outpatient (1.9%) and Medicaid Managed Care based on CMS marketbasket.
- Hospital Incentive Program (HIP), enacted in the FY 2016 budget, (now referred to as the Health System Transformation Program – see Section 9 below) remains in the FY 2017 budget and is contingent on CMS approval and use of federal funds. Estimated at approximately $25 million and payments are expected to begin by October 1, 2016.

Section 3 – Uncompensated Care

- Base year is updated to 2015 for FY 2017 DSH program.
  - 2016 DSH aggregate limit = $138.2 million (for pools A, C and D)
  - 2017 DSH aggregate limit = $139.7 million for pool D
    - For FY 2017 there is no longer any reference to pools A (Slater, Bradley and Butler) or pool C (Women & Infants).
    - DSH is restored and maximized for both years.
    - Since there is no pool A or C noted in FY 2017, all DSH monies will be paid to all hospitals in pool D.
  - UPL is restored and maximized at $19.2 million for FY 2017.

Section 9 – Medicaid Reform Act of 2008 Resolution

This section adds to the Rhode Island Medicaid Reform Act an Alternative Payment Arrangement program. EOHHS proposes to seek a 1115 waiver from CMS of a Medicaid State Plan Amendment to implement a R.I. Health System Transformation Program. EOHHS proposes to fund the program by seeking federal authority for federal financial participation (FFP) in
financing both Costs Not Otherwise Matchable (CNOMS) and Designated State Health Programs (DSHPs) that either not previously utilized although authorized or were not authorized for federal financial participation prior to June 1, 2016 and for which authority is obtained after June 1, 2016.

Utilizing the funds made available by this new authority for federal financial participation, the R.I. Health System Transformation Program will make payments to health care providers to reward and encourage improvements in clinical quality, patient experience and health system integration. Eligibility for these Health System Transformation Program payments will be made to health care providers participating in Alternative Payment Arrangements including, but not limited to, accountable entities and to those engaged in electronic exchange of clinical information necessary for optimal management of patient care.

**Other – Graduate Medical Education (GME)**

Since the House rejected the Governor’s proposal to eliminate the GME program for RI Hospital, the program remains in the budget. Same as prior two (2) years - which was denied by CMS - pool of up to $5M per year ($2.5M of state funds) in GME payments for facilities meeting certain criteria (RI Hospital only).

**Article 13 – Taxes and Revenue**

**Section 7 – Hospital License Fee**

- FY 2016 = 5.862% (as approved last year)
- FY 2017 = 5.652% (generates same amount as FY 16)
- Washington county waiver language in for FY 16 and FY 17
Commissions and Workgroups
Special Legislative Commission – Council to Coordinate Resources for Individuals with Rare Diseases

Created in 2016, the Commission was established by the State of Rhode Island General Assembly. The Commission was created to study and develop recommendations for coordinating efforts of state resources, private entities, and social services in order to effectively provide care for Rhode Island residents with rare diseases, along with their caregivers. Members of the Commission include members of the Rhode Island House of Representatives, the Rhode Island Department of Health, the Rhode Island Hospital Association, one individual diagnosed with a rare disease, one caregiver of an individual diagnosed with a rare disease, the Associate Dean of Medicine for Public Health and Policy at the Alpert Medical School at Brown University, and the President of the Rhode Island Public Health Association.

A rare disease is defined as a disorder that affects less than 200,000 people at any given time. There are currently 7,000 rare diseases that affect 30 million Americans. Many of these diseases are difficult to diagnose, because of their rarity. The Commission intends to better comprehend the difficulties that individuals with rare diseases face, in order to find more effective practices that can be utilized by the state.

Chaired by Representative Katherine Kazarian, the Commission met four times from October, 2015 to March of 2016. During its meetings, the Commission heard several presentations from individuals currently diagnosed with rare diseases, their caregivers, Blue Cross Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, The Rhode Island Department of Health, Care New England, and various physicians, among others.

The following presentations were made to the Commission during its proceedings:

- Dr. Ailis Clyne, physician and medical director at DOH, spoke about current programs and activities at the Department of Health related to assisting and supporting those with rare diseases.
  - DOH offers the following programs and resources: the Office of Special Needs, the Newborn Screening Program, and the Birth Defects Program.
- Several individual with rare diseases and parents of those with rare diseases also addressed the Commission describing their personal difficulties in finding care, the high costs associated with care, and other issues that they face due to the diagnosis of a rare disease.
- Brenda McGovern, Director of Case Management for BCBSRI, described how a complex case management model is used, and how a team-like atmosphere is created by including different providers of care and support services.
• Dr. Francisco Trilla, CMO at Neighborhood Health Plan RI also addressed coordination and communication, and their importance in improvement of care.

The Commission concluded that something needs to be done and the work should continue to investigate potential legislative and/or regulatory options. Better communication were common suggestions throughout the meeting presentations and are targeted as important in achieving the Commission’s goals. As a result, Representative Kazarian sponsored Resolution 249 removing the Commission’s expiration date and allowing its work to continue.

EOHHS – 1115 Waiver Implementation Task Force

Created in 2009, the 1115 Waiver Implementation Task Force was originally convened with membership from public interest groups and government parties to work toward a common goal: cost-effective, quality services for the Medicaid population. Throughout the year the Task Force focused on the following initiatives: Clinical/Functional Eligibility Criteria, Prescription Drug Overdose Prevention, and Managed Care Service Delivery Options for Adult Medicaid Beneficiaries.

Clinical/Functional Eligibility Criteria:

Effective January 1, 2016, the clinical/functional eligibility criteria must be met for Medicare beneficiaries being admitted into intermediate care facilities, hospitals and nursing facilities. These criteria vary according to the level of need of the beneficiaries, the scope of services provided, and state and federal regulatory requirements.

Prescription Drug Overdose Prevention for States Project

This program was designed to implement a multi-agency, comprehensive approach to reduce the number of fatal drug overdoses in Rhode Island. Through the following four strategies, the Task Force plans to ensure safe prescribing and improve recovery services:

• **Strategy One**: Enhance and Maximize PDMP – Increase registration in the Prescription Drug Monitoring Program, and ensure that the PDMP is easy to access and utilize, decrease PDMP Data Collection Interval to 24 hours, expand PDMP as a public health surveillance system.
• **Strategy Two**: Implement Community Interventions—creation of a multi-disciplinary data-focused group, coordinate intensive prevention efforts aimed at high-burden communities, updating Evidence-based Opioid Prescribing Guidelines.

• **Strategy Three**: Evaluate law, policies and regulations – Evaluating PDMP law requiring registration, mandating the reporting of opioid overdose, evaluating laws and regulations impacting naloxone accessibility and use.

• **Strategy Four**: Rapid Response Project (RPP) - reviewing drug overdose deaths to identify trends in overdose, followed by mini-grants made available for campaigns to educate the public and create awareness about prescription drug overdose.

**Managed Care Service Delivery Options for Adult Medicaid Beneficiaries**

This rule sets respective roles and responsibilities of EOHHS, beneficiaries and contractual entities serving Integrated Health Care Coverage groups enrolling in and receiving services through managed care. This rule references the eligibility requirements for members in these groups beginning April 1, 2016.

**Governor’s Healthcare Innovation Working Group**

Governor Raimondo established a statewide initiative in July of 2015, with the goals of improving healthcare and lowering the cost of care for Rhode Islanders. The Healthcare Innovation Working Group was composed of various stakeholders with experience in healthcare delivery, patient and consumer rights, health insurance, and public health who examined and developed recommendations for improving the quality and cost of healthcare in Rhode Island.

The Working Group was tasked with the following four sets of deliverables:

1. Developing benchmarks and a plan to establish a health spending cap for Rhode Island;
2. Identifying an implementation plan to achieve the “80 by ‘18” goals, which tie 80 percent of healthcare payments to quality by 2018;
3. Developing a vision for next-generation health information technology systems for all payers to improve care and reduce waste in the system, and;
4. Establishing performance management frameworks to achieve population health and wellness goals outlined by the CDC’s Healthy People 2020 report, and supporting and coordinating healthcare reform that is already underway in Rhode Island.
After several meetings, the Working Group presented their recommendations on December 1, 2015. The group acknowledged the need for reform in Rhode Island, due to the rising cost of healthcare. Their goals include the “Triple Aim”- improving the health of Rhode Islanders, improving the experience of care, and reducing per capita costs as well as making Rhode Island a leader in healthcare innovation, eliminating waste, fraud and abuse, and improving quality affordability and efficiency.

The Working Group developed four recommendations to help achieve the goals of the initiative:

1. The creation an Office of Health Policy which will set goals and oversee effective implementation statewide. The Office must be able to coordinate policy effectively, as to ensure that payors and providers interact with fewer state agencies.

2. Hold the healthcare system accountable for cost and quality, and using a spending target to increase transparency.

3. Expand the state’s healthcare analytic capabilities to drive improved quality of sustainable costs.

4. Align policies around alternative payment models, population health, health information technology and other priorities.

   - Encourage the use of alternative payment models, population health goals, and health information technology are important aspects of the state’s reform.
   - Move away from the dominant fee-for-service method toward alternative payment models, and requiring Medicaid to have 80% of payments tied to value and 50% of payments through and alternative payment model by 2018 will help the state achieve the “80 by ‘18” goals.
   - A statewide integrated population and behavioral health plan will be a crucial factor to achieving the goals of the Working Group. Population health goals are defined by three priorities, addressing the social and environmental determinants of health, eliminating the disparities of health and promotion of health equity, and ensuring access to quality health services for all Rhode Islanders.
   - Expansion and improvement in the utilization of health information technology (HIT) will enable the assessment of public health, measurement of quality and cost of care, determination of payments, and patient engagement.
Governor’s Overdose Prevention and Intervention Task Force

In response to the statewide overdose epidemic, the Governor’s Task Force on Drug Overdose focused on developing a coordinated effort among government agencies, law enforcement, health providers, substance use disorder providers, recovery services, and supports. The Task Force is Co-chaired by the Directors of DOH and BHDDH, and has met monthly since August, 2015.

Earlier this year, the Task Force released a strategic plan focused on the following four specific strategies that are designed to cut the number of lives lost to overdose in the state by one-third in three years:

1. **Prevention**: take aggressive measures to improve patient safety and better monitor opioid use through the Prescription Drug Monitoring Program (PDMP).
   - Safer prescribing: enrolling 100% of prescribers in the PDMP by June 2016, issuing clinical guidelines for co-prescribing opioids and benzodiazepines, and supporting resources for non-opioid therapy
   - Reducing the Supply (Rx): ensuring that opioid prescriptions are targeted to populations with the highest need, developing, implementing and enforcing regulations limiting opioid dosing, restricting opioid prescriptions from emergency rooms to three days or less, and promoting non-opioid therapies for chronic pain
   - Reducing Demand (Illicit): creating partnerships with community organizations and law enforcement to reduce demand for heroin and other illicit drugs, and working with the Fusion Center along with participating in the multi-state Heroin Response Strategy. The Fusion Center- Heroin Response Strategy foresees a 15-state regional partnership to address heroin and opioid use and trafficking, which strengthens the role of the Office of State Medical Examiners in reducing supply and demand for illicit drugs by locating and securing heroin stamp data within local law enforcement

2. **Rescue**: Ensure access to naloxone.
   - Naloxone saves lives, and Rhode Island plans to increase naloxone prescriptions, establish a centralized and sustainable fund to ensure an ample supply of naloxone, ensure that every community in Rhode Island has access to naloxone, and that first responders are trained in how to administer this life-saving drug.

3. **Treatment**: Expand the quality and availability of medication assisted treatment (MAT).
   - MAT lowers the risk of death, relapse, and incarceration, and is most effective as a long-term treatment, however, there is a shortage of physicians in Rhode Island who are trained and waivered to prescribe these effective treatments. Rhode Island will train
420 providers by 2018, expand access to MAT, create and staff its first Center of Excellence in 2016, and offer MAT to the Department of Corrections.

4. **Recovery**: Expand access to peer-recovery services and MAT.
   - It is important to expand peer-recovery services in order to support effective recovery for more individuals. Rhode Island will double the number of certified peer recovery specialists by March 2017, certify a network of recovery houses across the state, and develop a model discharge and recovery plan to promote recovery services.

In addition to these four strategies, EOHHS, DOH, BDDH, and other community partners will develop and implement a public education and communication plan. Additionally, General Assembly leaders have been essential to addressing the overdose crisis, through the passing of several bills (detailed earlier in the report) that allow the goals of the Overdose Prevention and Intervention Task Force to be reached.

**Health Care Planning and Accountability Advisory Council**

Under the co-chairmanship of the Secretary of EOHHS and OHIC, the Health Care Planning and Accountability Advisory Council (HCPAAC) was appointed in the summer of 2012 and convened that fall. The council consists of a broad spectrum of health care industry leaders including representatives of HARI, CharterCare Health Partners, Care New England Health System and South County Hospital. This year, the work of the Council focused on behavioral health care and substance abuse, and state wide health planning.

**Behavioral Health Care and Substance Abuse**

The State had requested an independent assessment of behavioral health care and substance abuse in Rhode Island, covering statewide demand, costs and supply across the lifespan of patients. Truven Analytics presented the final report of the behavioral health care study. The study found that Rhode Island has higher rates of unemployment, a higher presence of ADHD, and more illicit drug use than other New England states and nationally. The state also has a slightly higher rate of mental illness than the national average over the past year. Additionally, behavioral health hospitalizations are significantly higher in Rhode Island than in other New England states. Rhode Island is investing significantly in meeting the behavioral health needs of its residents, however, Rhode Island is ranked 24th nationally in spending on behavioral health care, which is relatively low. There is a need for more behavioral health care services in Rhode
Island, and the state has an adequate supply of facilities and professionals to provide care, so cost-effective results could be strengthened.

Truven Analytics recommends that Rhode Island invest in proven, effective preventative services and supports for children and families, shift financing from high-cost intensive and reactive services toward evidence-based services, and promote a population-based approach to behavioral healthcare by enhancing state and local infrastructure. Overall, Rhode Island has greater behavioral health needs than other states, and is not getting the best value for the money that is being spent.

**Statewide Health Planning**

DOH is conducting a statewide health planning initiative, to assess and describe capacity, utilization and access to health care in Rhode Island, and a written report will be distributed to the General Assembly once fully completed.

**OHIC – Administrative Simplification Workgroup**

The Administrative Simplification Workgroup held seven two-hour meetings between September 2015 and January 2016. The Workgroup focused on four key areas: value-enhancing plan design components, primary care provider designation, network tiering and surprise/silent billing and created recommendations for the Commissioner. The Workgroup submitted its report to the Commissioner in February of 2016.

In the report, recommendations and findings were focused on the following issues:

**Value-Enhancing Plan Design Components**

Representatives from various insurance companies that service the state presented on plan design components that are currently in place, including:

- Value based network tiering- Many commercial health plans separate the providers they cover into tiers with different out-of-pocket costs for consumers, with the aim of incentivizing consumers to seek services from providers that are better able to integrate care across the network.
- Case management program participation- Structuring cost sharing to incentivize participation in disease management programs for specific chronic conditions, including
access to nurses, dieticians, behavioral health care, and other providers to assist in managing chronic conditions.

- Monthly/periodic copays for chronic disease categories- Allowing consumers with chronic conditions to pay a flat monthly copay to access all necessary services to manage their condition will remove barriers to care access and limit the need for higher-cost services.
- Primary care provider designation- All health insurers must ask their customers to designate a primary care physician (PCP) at the time of enrollment, per Rhode Island law, however, customers cannot be denied enrollment for declining to designate a PCP.

Primary Care Provider (PCP) Designation

Any action taken should increase the number of consumers who have and use a PCP to coordinate the customer’s care, educate consumers on the importance of having a PCP, and move the healthcare system toward care coordination to meet the patient’s needs. The Workgroup made the following recommendations on PCP designation:

- Establish a definition of “Primary Care Provider” that is consistent with OHIC’s Regulation 2 and the Affordability Standards, and that considers efforts of OHIC’s Care Transformation Committee and OHIC’s Alternative Payment Methodology Committee.
- Carriers may automatically assign the consumer to a PCP if the consumer declines or is unable to designate a PCP at the time of plan enrollment or renewal.
- Consumers should be able to change their designated PCP in a simple manner that does encourage them to maintain a relationship with a PCP but does not interrupt access to care.
- The Commissioner should encourage more consumers to designate a PCP and consistently use and build a relationship with their PCP.
- A report should be made to OHIC annually on the progress of PCP designation.

Network Tiering

Consumers should have access to and understand information that allows them to make a reasonably informed comparison of provider networks. The Workgroup made the following recommendations on network tiering:

- Carriers should develop a process and communications strategy to more effectively educate provider network variables to consumers to help them understand how their plan network(s) work.
- The Commissioner should set a date by which carriers must develop and implement such a strategy.
- A Frequently Asked Questions (FAQ) document is suggested as a potentially effective way to communicate network details to consumers.
**Surprise/Silent Billing**

The issue of surprise/silent billing is a growing concern, and requires that stakeholders work together to address the issue as soon as possible. The Workgroup made the following recommendations on surprise/silent billing:

- Examine current statutes and regulations regarding surprise/silent billing that are under the direct jurisdiction of the RI Department of Health to determine if any requirements exist that apply to surprise/silent billing.
- Consumers should be notified of their rights and available options in the event of surprise/silent billing, at a minimum, a process to inform consumers of these rights and options should be available.

**State Innovation Model (SIM)**

The State Innovation Model was created to improve the performance of Rhode Island’s healthcare system, improve the quality of care, and cut costs for Medicare, Medicaid, and the Children’s Health Insurance Program. Rhode Island was awarded approximately $1.6 million by CMS in February of 2013 to improve the healthcare system in the first round of grants. In July of 2014, CMS awarded Rhode Island an additional $20 million in the second round of awards to further develop the State Innovation Model over the next four years.

The Rhode Island SIM Theory of Change concentrates on changing the payment system to focus on value rather than volume, and making investments to support providers and empower patients to adapt these changes. By making changes to the payment system, making investments in technology infrastructure, system transformation, and provider capacity, and evaluating these investments, the hope is that population health will improve and Rhode Island will move toward the vision of the Triple Aim, which includes improving patient experience of care, improving population health and reducing per capita costs, and additionally, ensuring provider satisfaction. Objectives such as better internal state processes, effective external stakeholder processes and improved data analytics capacity will help the SIM Steering Committee to move toward program aims.

The following SIM Guiding Principles describe the overall work of the SIM project, developed by the SIM Steering Committee:
• Commitment to empowering individuals, families and communities to improve their own health.
• Reliance on multi-sector/multi-agency collaboration.
• Commitment to improve our ability to collect, share and use data to drive action.
• Use an integrated approach to the physical and behavioral needs of Rhode Islanders.
• Commitment to transforming our health care delivery system, moving away from a fee for service based payment model to a value based approach.
• Awareness of the social and environmental determinants of health and health equity.
• Consistent and reliable support for provider practice transformation.
• Address disparities.

Following a strategic discussion to make funding decisions at the SIM Steering Committee Meeting on January 28, 2016, the following funding proposals were presented:

**Investment in Rhode Island’s Healthcare Workforce- Practice Transformation:**

• Community Health Teams (CHTs): the certification of community health workers in the state will be investigated and training will be provided to ensure that other organizations know how to work with the CHTs.
• PCMH Kids/Child Psychiatry Access Program (CPAP): this will allow PCPs to refer patients to a child psychiatrist when the PCP feels they are unable to treat a behavioral health crisis. PCPs will also receive training from psychiatrists to encourage provision of more behavioral healthcare delivery in PCP offices.
• Behavioral Health Transformation: Including Screening, Brief Intervention and Referral to Treatment (SBIRT) to facilitate early identification and intervention with substance use disorders, care management dashboard for community mental health centers, and a Practice Transformation Coaching Program for integrated health homes to establish an integrated continuation of care for patients with serious mental illness to ensure that behavioral health staff are a regular part of primary care practice.
• Healthcare Quality, Measurement Reporting, and Feedback System: Reduce the reporting burden on providers by establishing a data intermediary to accept, calculate, benchmark and provide feedback quality reporting data to providers, send quality measures to payers, and publicly report quality measures to support making informed healthcare decisions.

**Patient Empowerment and Engagement:**

• Patients who are more engaged in their care are generally healthier, so it is suggested that patients are provided with access to tools to increase their engagement in their own care and create an infrastructure that allows patients to share their advanced care directives and healthcare proxies.
Increasing Data Capability and Expertise:

- Implement and Use the Statewide Common Provider Directory: Merge provider data from multiple sources into a single record, maintain real-time and historical provider to organization relationships, use provider relationship data in evaluation of value based purchasing and quality measurement, create a public portal to search for and locate providers.
- All Payer Claims Database (HealthFacts RI): Support and maintain collection, validation, analytics and report development of HealthFacts RI data and ensuring that data is ready for use.
- State Agency Data and Analytics Infrastructure: Foundational funding to modernize the state’s current Human Services Data Warehouse and create a data ecosystem that will be integrated, use analytics, tools, benchmarks and visualization.

The assimilation of the SIM Operations Plan with the Integrated Population Health Plan, which focuses on tobacco, obesity, chronic illness and behavioral health issues, will maximize the effectiveness of both plans, help reduce social health disparities, avoid duplication, serve more individuals and potentially save the state money. Additional input from the community will help to continue the work on the Integrated Population Health Plan and link healthcare services throughout the state. The integration of both programs will lead to an overall improvement in population health and create more patient and provider engagement patient care throughout the state.
Position Letters
and
Testimony
January 26, 2016

The Honorable Brian Patrick Kennedy
Chairman, House Corporations Committee
State House, Room 328
82 Smith Street
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island and its members strongly support your bill, H.7160. The referenced legislation seeks to require insurers to include coverage for telemedicine services on plans or contracts issued, renewed, or delivered on or after January 1, 2018.

HARI and its members have taken an active role in working with the state to transform the health care delivery system to better serve patients while reducing overall costs. Telemedicine is a cost-effective method of delivering quality, coordinated care. Its utilization by health care providers results in improved patient outcomes, including better management of chronic diseases, which is a significant driver of health care costs. Telemedicine also assists in patient education and self-management of their health and medical condition, leading to more effective patient engagement with their health care team.

Our members believe that enactment of this measure is a necessary step in helping transform the state’s health care delivery system to a more patient-centered, provider collaborative approach. Rhode Island would join several states, including most recently Connecticut, in recognizing the use of telemedicine technology as an effective tool in providing patients high quality health care, at a lower cost.

HARI and its members strongly urge the passage of H.7160. We welcome the opportunity to work with you, and all interested parties in this important initiative to enhance the delivery of health care to Rhode Islanders.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
March 8, 2016

The Honorable Joshua B. Miller  
Chairman  
Senate Health and Human Services Committee  
State House, Room 318  
Providence, RI 02903

Dear Chairman Miller:

The Hospital Association of Rhode Island and its members strongly support S.2577, sponsored by Senator Gayle Goldin. The referenced legislation seeks to require insurers to include coverage for telemedicine services on plans or contracts issued, renewed, or delivered on or after January 1, 2018.

HARI and its members have taken an active role in working with the state to transform the health care delivery system to better serve patients while reducing overall costs. Telemedicine is a cost-effective method of delivering quality, coordinated care. Its utilization by health care providers results in improved patient outcomes, including better management of chronic diseases, which is a significant driver of health care costs. Telemedicine also assists in patient education and self-management of their health and medical condition, leading to more effective patient engagement with their health care team.

Our members believe that enactment of this measure is a necessary step in helping transform the state’s health care delivery system to a more patient-centered, provider collaborative approach. Rhode Island would join several states, including most recently Connecticut, in recognizing the use of telemedicine technology as an effective tool in providing patients high quality health care, at a lower cost.

HARI and its members strongly urge the passage of H.2577. We welcome the opportunity to work with you, Senator Goldin, and all interested parties in this important initiative to enhance the delivery of health care to Rhode Islanders.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza  
President
March 8, 2016

The Honorable Brian Patrick Kennedy  
Chairman, House Corporations Committee  
State House, Room 328  
82 Smith Street  
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island and its members support bill H.7616 by Representative David Bennett. The referenced legislation seeks to provide better insurance coverage and continuity of care for individuals with behavioral health and substance use disorders.

Our members strongly support insurance coverage for anti-opioid and anti-opiate drugs as well medications used for the treatment of substance use disorders. In addition, we fully support the bill’s provisions that would provide coverage for medication-assisted treatment or medication-assisted maintenance services of substance use disorders.

The measure would also allow for facilities to include recover planning tools in discharge plan for patients with substance use disorders. It also would require facilities to assist patients, with their consent, to obtain a follow-up appointment with specific treatment options. Additionally, it would allow individuals presenting, with indication of a substance use disorder, to hospitals, clinics or urgent care centers to receive information on availability of clinically appropriate in-patient or out-patient treatment and service options.

Hospitals in Rhode Island agree with the need for a transition process to ensure patients with substance use disorders leave our facilities with the appropriate access to and information about the community-based facilities and providers. Aftercare is critical and community supports are vital for the treatment of Rhode Islanders with substance use disorders. Our members look forward to working closer with the entire provider community to assist patients leaving our facilities in obtaining the essential follow-up care they will need to stay healthy and productive.

We welcome the opportunity to work with you, Representative Bennett, and all interested parties to enhance the care Rhode Islanders with substance abuse disorders receive.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza  
President
March 15, 2016

The Honorable Joshua B. Miller
Chairman
Senate Health and Human Services Committee
State House, Room 318
Providence, RI 02903

Dear Chairman Miller:

The Hospital Association of Rhode Island and its members support your bill S.2356. The referenced legislation seeks to provide better insurance coverage and continuity of care for individuals with behavioral health and substance use disorders.

Our members strongly support insurance coverage for anti-opioid and anti-opiate drugs as well medications used for the treatment of substance use disorders. In addition, we fully support the bill’s provisions that would provide coverage for medication-assisted treatment or medication-assisted maintenance services of substance use disorders.

The measure would also allow for facilities to include recover planning tools in discharge plan for patients with substance use disorders. It also would require facilities to assist patients, with their consent, to obtain a follow-up appointment with specific treatment options. Additionally, it would allow individuals presenting, with indication of a substance use disorder, to hospitals, clinics or urgent care centers to receive information on availability of clinically appropriate in-patient or out-patient treatment and service options.

Hospitals in Rhode Island agree with the need for a transition process to ensure patients with substance use disorders leave our facilities with the appropriate access to and information about the community-based facilities and providers. Aftercare is critical and community supports are vital for the treatment of Rhode Islanders with substance use disorders. Our members look forward to working closer with the entire provider community to assist patients leaving our facilities in obtaining the essential follow-up care they will need to stay healthy and productive.

We welcome the opportunity to work with you and all interested parties to enhance the care Rhode Islanders with substance abuse disorders receive.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
March 8, 2016

The Honorable Brian Patrick Kennedy  
Chairman, House Corporations Committee  
State House, Room 328  
82 Smith Street  
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island and its members support bill H.7710 by Representative David Bennett. The referenced legislation seeks to provide insurance coverage for all opioid antagonists and all necessary related devices for the administration of an opioid antagonist.

HARI and its members are very concerned with the serious problems in Rhode Island surrounding the rise in unintentional overdoses from prescription opioids and the rise of substance use and addiction in general. We support the coverage all opioid antagonists (naloxone) to ensure accessibility to those in need, their families and friends. Rhode Island has been a leader in ensuring access to naloxone for first-responders, patients, family and friends through over the counter access. However, lack of funding has been a consistent barrier to naloxone access and use. This bill’s requirement of insurance coverage for opioid antagonists is critical to helping save lives in the event of an overdose.

Our members have also strongly supported insurance coverage for and access to abuse-deterrent opioid analgesic drugs, as well as drugs used for the treatment of substance use disorders. We believe coverage for opioid antagonists will further help save the lives of individuals struggling with addiction.

We welcome the opportunity to work with you, Representative Bennett, and all interested parties to enhance the care Rhode Islanders with substance abuse disorders receive.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
March 10, 2016

The Honorable Joshua B. Miller
Chairman
Senate Health and Human Services Committee
State House, Room 318
Providence, RI 02903

Dear Chairman Miller:

The Hospital Association of Rhode Island and its members support bill your bill, S.2460. The referenced legislation seeks to provide insurance coverage for all opioid antagonists and all necessary related devices for the administration of an opioid antagonist.

HARI and its members are very concerned with the serious problems in Rhode Island surrounding the rise in unintentional overdoses from prescription opioids and the rise of substance use and addiction in general. We support the coverage all opioid antagonists (naloxone) to ensure accessibility to those in need, their families and friends. Rhode Island has been a leader in ensuring access to naloxone for first-responders, patients, family and friends through over the counter access. However, lack of funding has been a consistent barrier to naloxone access and use. This bill’s requirement of insurance coverage for opioid antagonists is critical to helping save lives in the event of an overdose.

Our members have also strongly supported insurance coverage for and access to abuse-deterrent opioid analgesic drugs, as well as drugs used for the treatment of substance use disorders. We believe coverage for opioid antagonists will further help save the lives of individuals struggling with addiction.

We welcome the opportunity to work with you and all interested parties to enhance the care Rhode Islanders with substance abuse disorders receive.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
Business and Professions – Non-Competition Agreements

(H 7586 SUB A/S 2578 SUB A)

*Medicine and Long Term Care Associates v. Khurshid*
SILVERSTEIN, J. The Plaintiff, Medicine and Long Term Care Associates, LLC. (MLTC), is a Rhode Island limited liability company; its principal place of business is in Cranston, Rhode Island. The Defendant, Doctor Shahzad Khurshid (Khurshid), is a resident of North Kingstown, Rhode Island. This Court has jurisdiction over the subject matter of the instant dispute pursuant to G.L. 1956 §§ 8-2-13, 8-2-14, and 9-30-1.

I

Facts and Travel

MLTC was organized for the purpose of providing health care services and has been providing health care services—primarily to geriatric patients in nursing homes—since its date of incorporation. In May of 2009, MLTC and Khurshid entered into an Association Agreement (Agreement) whereby Khurshid agreed to provide “services for the benefit of the patients of MLTC on a mutually agreed upon schedule.” Agreement, 1. The Agreement guaranteed Khurshid compensation in exchange for his services, but also contained an “Exclusivity and Non-Competition” clause. Id. at 3. Under the Exclusivity and Non-Competition clause, Khurshid was prohibited from soliciting or attempting to solicit MLTC employees, agents,
contractors, referral sources, or patients for two years after termination or expiration of the Agreement. Additionally, under the Exclusivity and Non-Competition clause, and for two years after termination or expiration of the Agreement, Khurshid was prohibited from causing or inducing any employee, agent, supplier, vendor, contractor, referral source, or patient of MLTC to terminate or suspend its business with MLTC. Finally, under the Exclusivity and Non-Competition clause, and for two years after termination or expiration of the Agreement, Khurshid was prohibited from maintaining an office practice within nine miles of MLTC’s principal place of business.

In addition to the above-described Exclusivity and Non-Competition clause, the Agreement contained the following acknowledgement: “Khurshid[] acknowledges that irreparable harm will result to MLTC’s Private Practice upon breach of the covenants contained in the Confidentiality and Non-Solicitation sections of this Agreement. In addition to all other available remedies, MLTC may obtain injunctive relief to enforce the specific covenants contained herein.” Id.

Khurshid remained associated with MLTC until at least December of 2014. As an associate, Khurshid was assigned patients in nursing home facilities, and Khurshid provided care to those patients.

On December 28, 2014, Khurshid sent a letter to MLTC informing them of his intent to terminate the Agreement. On or about January 1, 2015, MLTC received notice from the John Clarke Retirement Center of its intent to terminate its contract with MLTC.¹ On or about January 7, 2015, MLTC sent a letter to Khurshid informing him that it had “come to the attention of MLTC that [Khurshid] may have engaged in some activity which is in direct violation of the

¹ In its Complaint, MLTC alleges that “[u]pon information and belief the [John Clarke Retirement Center] has retained [Khurshid].” Compl. ¶ 17.
Exclusivity and Non-Competition clause in the [] Agreement.” Letter from Atty. Gianfrancesco to Khurshid dated Jan. 7, 2015. The letter went on to state that Khurshid was “directed to cease and desist in any such activity,” and that Khurshid’s “failure to do so will result in MLTC taking further appropriate action pursuant to the [] Agreement.” Id.

On February 3, 2015, MLTC filed a Complaint in Superior Court, wherein it named Khurshid as Defendant and alleged the following: Unfair Competition (Count I), Breach of Fiduciary Duty (Count II), Tortious Interference with Advantageous Relations (Count III), and Tortious Interference with Prospective Contractual Relations (Count IV). In addition to compensatory damages, attorney’s fees, interests, and costs, MLTC, in its Complaint, prayed for the following relief: a declaratory judgment stating that Khurshid (1) engaged in unfair competition, (2) breached his fiduciary duties, (3) tortiously interfered with advantageous business relations, and (4) tortiously interfered with prospective contractual relations; injunctive relief prohibiting Khurshid from using business relationships established—and confidential information developed—while he was associated with MLTC; an award of punitive damages; and an award of exemplary damages pursuant to G.L. 1956 § 6-41-4. On July 22, 2015, Khurshid filed an Answer in response to MLTC’s Complaint. Khurshid’s Answer denies Counts I-IV, raises eleven separate affirmative defenses, and includes multiple counterclaims.

This Decision will address only MLTC’s above-mentioned prayer for injunctive relief. Although the Court finds that MLTC has alleged facts and presented evidence which otherwise might entitle it to injunctive relief, for the reasons set forth below, the Court denies MLTC’s prayer.
II

Analysis

MLTC prays for injunctive relief as a remedy to the harm resulting from Khurshid’s alleged violation of the above-described Exclusivity and Non-Competition clause. “A decision to grant or deny . . . injunctive relief is addressed to the sound discretion of the trial justice. . .” Hagenberg v. Avedisian, 879 A.2d 436, 441 (R.I. 2005). However, a trial justice may not grant injunctive relief unless the party seeking such relief demonstrates that “it stands to suffer some irreparable harm that is presently threatened or imminent and for which no adequate legal remedy exists to restore that plaintiff to its rightful position.” Fund for Cmty. Progress v. United Way of Se. New England, 695 A.2d 517, 521 (R.I. 1997). A demonstration of irreparable harm is to be made “at the conclusion of all the evidence,” R. I. Tpk. & Bridge Auth. v. Cohen, 433 A.2d 179, 183 (R.I. 1981), and is to be based upon the totality of the circumstances, Sch. Comm. of Pawtucket v. Pawtucket Teachers’ Alliance Local No. 930, 117 R.I. 203, 208, 365 A.2d 499, 502 (1976), rather than an individual fact or contractual provision.

A party seeking injunctive relief must “show that it has a reasonable likelihood of succeeding on the merits of its claim” by making out a prima facie case related to the claim. Fund for Cmty. Progress, 695 A.2d at 521. If the party seeking injunctive relief is able to show that it stands to suffer irreparable harm for which no adequate legal remedy exists, “the trial justice should next consider the equities of the case by examining the hardship to the moving party if the injunction is denied, the hardship to the opposing party if the injunction is granted and the public interest in denying or granting the requested relief.” Id. A party seeking an injunction must demonstrate “that the public-interest equities weigh in favor of the injunction.” Nat’l Lumber & Bldg. Materials Co. v. Langevin, 798 A.2d 429, 434 (R.I. 2002).

Whereas animals, as the Block court noted, “are such agreeable friends—they ask no question, they pass no criticisms,” id. at *3, people are encouraged to confide in their health care providers, and thus have an “imperative need for confidence and trust” with respect to physicians. State v. Almonte, 644 A.2d 295, 306 (R.I. 1994); see also § 9-17-24 (privileging communications between a patient and his or her physician). In Massachusetts, state law prohibits the enforcement of restrictive covenants against physicians, Mass. Gen. Laws Ann. ch. 112, § 12X (West), and courts in that jurisdiction have held that “[t]he statute favors ‘[t]he strong public interest in allowing [patients] to [consult the physician] of their choice.’” Falmouth Ob-Gyn Assocs., v. Abisla, 417 Mass. 176, 182, 629 N.E.2d 291, 294 (1994) (quoting Meehan v. Shaughnessy, 404 Mass. 419, 431, 535 N.E.2d 1255 (1989)).

III

Conclusion

Even in the absence of a Rhode Island statute similar to the above-mentioned Massachusetts law, this Court believes that the strong public interest in allowing individuals to retain health care service providers of their choice “outweighs any professional benefits derived from a restrictive covenant.” Meehan, 404 Mass. at 431, 535 N.E.2d at 1262. On this basis, the
Court denies MLTC’s request for injunctive relief. The Court notes, however, MLTC’s statement that “[i]t will lose tens of thousands of dollars in revenue as a result of Defendant’s wrongful conduct,” Compl. ¶ 23, and leaves it to seek legal redress for its injuries.

The prevailing party shall present an order consistent herewith, and the parties are directed to confer with the Court with respect to scheduling further proceedings.
TITLE OF CASE: Medicine and Long Term Care Associates, LLC. v. Khurshid

CASE NO: PC-2015-0458

COURT: Providence County Superior Court

DATE DECISION FILED: March 29, 2016

JUSTICE/MAGISTRATE: Silverstein, J.

ATTORNEYS:
For Plaintiff: Anthony J. Gianfrancesco, Esq.
For Defendant: Kathleen M. Hagerty, Esq.
February 23, 2016

The Honorable Brian Patrick Kennedy
Chairman, House Corporations Committee
State House, Room 328
82 Smith Street
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island (HARI) and its members support bill H.7500, sponsored by Representative Patricia Serpa. The referenced legislation seeks to regulate freestanding emergency care facilities ("freestanding EDs") under the state health care facility licensing statute the same way hospital emergency departments are currently regulated. The measure would also subject all future freestanding ED licensure applications to the certificate of need process. HARI and its members take their roles in the broader health care community very seriously, and have several concerns with the opening of freestanding EDs in Rhode Island and their impact on the delivery system as a whole.

Currently, freestanding EDs are not eligible under CMS guidelines to participate in Medicaid or Medicare. As a result, our members are concerned with regard to a freestanding ED's ability to provide care to patients who may present at their doors who are either uninsured, underinsured, or have coverage through Medicaid and/or Medicare and increased or unknown financial liability to these patients. Additionally, freestanding EDs would not be subject to the state’s requirements on hospitals to provide charity care to the uninsured. Our members strongly feel that providing access to care for all Rhode Islanders in need is a key component of the state’s current health care delivery system and should also be applicable to freestanding EDs.

As active members of Rhode Island’s health care community, HARI’s members participate in several coordination of care and reform efforts and we are concerned about the potential impact on coordination of care with a patient’s primary care provider, specialist, hospital, long-term care facility or home care provider should a patient need additional services and/or follow-up care.

Additionally, the state of Rhode Island as well as commercial insurers have been implementing reforms in recent years to move health care delivery away from more costly settings, including EDs. Our members believe that a licensure and certificate of need process similar to the requirements on existing health care facilities is necessary to ensure that freestanding EDs do not undermine state system reform efforts.

HARI and its members support this bill to subject freestanding EDs to the same regulatory and licensure requirements in existence for other Rhode Island health care facilities. The creation of a level playing field will further ensure patient access to quality, affordable, care in the most appropriate setting.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
April 7, 2016

The Honorable Joshua B. Miller
Chairman
Senate Health and Human Services Committee
State House, Room 318
Providence, RI 02903

Dear Chairman Miller:

The Hospital Association of Rhode Island (HARI) and its members support your bill, S.2696. The referenced legislation seeks to regulate freestanding emergency care facilities ("freestanding EDs") under the state health care facility licensing statute the same way hospital emergency departments are currently regulated. The measure would also subject all future freestanding ED licensure applications to the certificate of need process. HARI and its members take their roles in the broader health care community very seriously, and have several concerns with the opening of freestanding EDs in Rhode Island and their impact on the delivery system as a whole.

Currently, freestanding EDs are not eligible under CMS guidelines to participate in Medicaid or Medicare. As a result, our members are concerned with regard to a freestanding ED's ability to provide care to patients who may present at their doors who are either uninsured, underinsured, or have coverage through Medicaid and/or Medicare and increased or unknown financial liability to these patients. Additionally, freestanding EDs would not be subject to the state’s requirements on hospitals to provide charity care to the uninsured. Our members strongly feel that providing access to care for all Rhode Islanders in need is a key component of the state’s current health care delivery system and should also be applicable to freestanding EDs.

As active members of Rhode Island’s health care community, HARI’s members participate in several coordination of care and reform efforts and we are concerned about the potential impact on coordination of care with a patient’s primary care provider, specialist, hospital, long-term care facility or home care provider should a patient need additional services and/or follow-up care.

Additionally, the state of Rhode Island as well as commercial insurers have been implementing reforms in recent years to move health care delivery away from more costly settings, including EDs. Our members believe that a licensure and certificate of need process similar to the requirements on existing health care facilities is necessary to ensure that freestanding EDs do not undermine state system reform efforts.

HARI and its members support this bill to subject freestanding EDs to the same regulatory and licensure requirements in existence for other Rhode Island health care facilities. The creation of a level playing field will further ensure patient access to quality, affordable, care in the most appropriate setting.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
March 23, 2016

The Honorable Joseph M. McNamara
Chairman, House Health, Education and
Welfare Committee
State House, Room 135
82 Smith Street
Providence, RI 02903

Dear Chairman McNamara:

The Hospital Association of Rhode Island (HARI) and its members oppose as written your bill, H.7448. The referenced legislation would require the presence of a circulating nurse trained in perioperative nursing to be present “during surgical or other invasive procedures” or in an operating room during a surgical procedure.

HARI and its members are committed to patient safety, but the language of the current bill is unclear as to when the presence of a circulating nurse would be required. Subparagraph (b) of section 1 of the bill would require the presence of a perioperative nurse in the operating room during a surgical procedure. However, taken in light of the definition of perioperative nurse includes presence “during a surgical or other invasive” procedure. The addition of “other invasive” procedure brings a level of uncertainty in the event of very minor procedures.

While we oppose this bill as written, we welcome the opportunity to work with you and the proponents of the bill regarding a clarification of language and potential adverse impact on hospitals. HARI and its members are committed to patient safety and look forward to working with you to ensure quality health care for all Rhode Islanders.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
March 22, 2016

The Honorable Joshua B. Miller
Chairman
Senate Health and Human Services Committee
State House, Room 318
Providence, RI 02903

Dear Chairman Miller:

The Hospital Association of Rhode Island (HARI) and its members oppose as written bill S.2469, sponsored by Senator Cynthia Coyne. The referenced legislation would require the presence of a circulating nurse trained in perioperative nursing to be present “during surgical or other invasive procedures” or in an operating room during a surgical procedure.

HARI and its members are committed to patient safety, but the language of the current bill is unclear as to when the presence of a circulating nurse would be required. Subparagraph (b) of section 1 of the bill would require the presence of a perioperative nurse in the operating room during a surgical procedure. However, taken in light of the definition of perioperative nurse includes presence “during a surgical or other invasive” procedure. The addition of “other invasive” procedure brings a level of uncertainty in the event of very minor procedures.

While we oppose this bill as written, we welcome the opportunity to work with the sponsor and proponents of the bill regarding a clarification of language and potential adverse impact on hospitals. HARI and its members are committed to patient safety and look forward to working with you to ensure quality health care for all Rhode Islanders.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
March 22, 2016

The Honorable Brian Patrick Kennedy  
Chairman, House Corporations Committee  
State House, Room 328  
82 Smith Street  
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island and its members support bill H.7163 by Representative John Edwards. The referenced legislation seeks to provide insurance coverage for abuse-deterrent opioid analgesic drug products.

HARI and its members are very concerned with the serious problems in Rhode Island surrounding the rise in unintentional overdoses from prescription opioids and the rise of substance use and addiction in general. We support the coverage of abuse-deterrent opioid analgesic drugs to ensure accessibility to consumers in need of such formulations. Having these classes of drugs covered by insurers in the same manner as opioid prescriptions will be helpful in stemming the rise of substance use and addiction in Rhode Island.

Our members have strongly supported insurance coverage for anti-opioid and anti-opiate drugs, as well as drugs used for the treatment of substance use disorders. We believe coverage for abuse-deterrent opioid analgesic drugs will further help providers address the issue of prescription drug use and addiction. Additionally, coverage of abuse-deterrent formulations will result in lower overall health care costs to the system by reducing the incidence of addiction and keeping Rhode Islanders in recovery healthier and more productive.

We welcome the opportunity to work with you, Representative Edwards, and all interested parties to enhance the care Rhode Islanders with substance abuse disorders receive.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza  
President
March 10, 2016

The Honorable Joshua B. Miller  
Chairman  
Senate Health and Human Services Committee  
State House, Room 318  
Providence, RI 02903

Dear Chairman Miller:

The Hospital Association of Rhode Island and its members support your bill, S.2461. The referenced legislation seeks to provide insurance coverage for abuse-deterrent opioid analgesic drug products.

HARI and its members are very concerned with the serious problems in Rhode Island surrounding the rise in unintentional overdoses from prescription opioids and the rise of substance use and addiction in general. We support the coverage of abuse-deterrent opioid analgesic drugs to ensure accessibility to consumers in need of such formulations. Having these classes of drugs covered by insurers in the same manner as opioid prescriptions will be helpful in stemming the rise of substance use and addiction in Rhode Island.

Our members have strongly supported insurance coverage for anti-opioid and anti-opiate drugs, as well as drugs used for the treatment of substance use disorders. We believe coverage for abuse-deterrent opioid analgesic drugs will further help providers address the issue of prescription drug use and addiction. Additionally, coverage of abuse-deterrent formulations will result in lower overall health care costs to the system by reducing the incidence of addiction and keeping Rhode Islanders in recovery healthier and more productive.

We welcome the opportunity to work with you, and all interested parties to enhance the care Rhode Islanders with substance abuse disorders receive.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza  
President
March 8, 2016

The Honorable Brian Patrick Kennedy  
Chairman, House Corporations Committee  
State House, Room 328  
82 Smith Street  
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island and its members support bill H.7617 by Representative David Bennett. The referenced legislation seeks to provide insurance coverage for abuse-deterrent opioid analgesic drug products.

HARI and its members are very concerned with the serious problems in Rhode Island surrounding the rise in unintentional overdoses from prescription opioids and the rise of substance use and addiction in general. We support the coverage of abuse-deterrent opioid analgesic drugs to ensure accessibility to consumers in need of such formulations. Having these classes of drugs covered by insurers in the same manner as opioid prescriptions will be helpful in stemming the rise of substance use and addiction in Rhode Island.

Our members have strongly supported insurance coverage for anti-opioid and anti-opiate drugs, as well as drugs used for the treatment of substance use disorders. We believe coverage for abuse-deterrent opioid analgesic drugs will further help providers address the issue of prescription drug use and addiction. Additionally, coverage of abuse-deterrent formulations will result in lower overall health care costs to the system by reducing the incidence of addiction and keeping Rhode Islanders in recovery healthier and more productive.

We welcome the opportunity to work with you, Representative Bennett, and all interested parties to enhance the care Rhode Islanders with substance abuse disorders receive.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza  
President
February 23, 2016

The Honorable Brian Patrick Kennedy  
Chairman, House Corporations Committee  
State House, Room 328  
82 Smith Street  
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island (HARI) and its members oppose bill H.7502, sponsored by Representative Thomas Palangio. With the exception of licensed medical practitioners, the referenced legislation would cap hospital employee compensation at a rate of 110% of the northeast regional average for comparable positions at comparable facilities.

Limiting salaries for key hospital personnel is deeply concerning to our members. Hospitals are unlike any other industry and present unique challenges for their managers and executives. They are open 24 hours a day, seven days a week, accept all patients regardless of ability to pay, and serve as the health care safety net for the most vulnerable Rhode Islanders. In addition to medical staff, most hospital employees require high educational achievement and technical skills to perform their jobs. Families throughout Rhode Island depend on well-run hospitals not only for their health, but also for their livelihood and economic welfare.

Rhode Island’s hospitals are committed to the mission of providing quality care. Experienced managers who can improve services in the face of diminishing resources become even more important. The compensation of hospital leaders is carefully set by boards, led by community members, who are charged with attracting and keeping the best leaders. They follow hospital policy and use competitive market data, just as is done for all hospital employee pay. Boards of trustees must be able to set executive compensation at levels sufficient to attract professional leaders who can improve services and quality of care in the highly competitive New England health care market.

Hospital leaders are responsible for the operation and performance of complex, dynamic public service organizations. They are charged with guiding their organizations through the ever-changing health care environment, with its numerous financial, regulatory, and public policy challenges, while always focusing on the core mission of patient care and safety.

We ask that you help Rhode Island hospitals continue to provide quality care in an increasingly competitive marketplace by not hampering their ability to recruit and retain top talent. Our hospitals are proud to care for Rhode Islanders through all stages of life, times of need, and economic conditions. Every year we serve thousands of individuals, keeping our communities healthy, strong and vibrant.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza  
President
March 1, 2016

The Honorable Joshua B. Miller
Chairman
Senate Health and Human Services Committee
State House, Room 318
Providence, RI 02903

Dear Chairman Miller:

The Hospital Association of Rhode Island (HARI) and its members oppose bill S.2559, sponsored by Senator Michael J. McCaffrey. With the exception of licensed medical practitioners, the referenced legislation would cap hospital employee compensation at a rate of 110% of the northeast regional average for comparable positions at comparable facilities.

Limiting salaries for key hospital personnel is deeply concerning to our members. Hospitals are unlike any other industry and present unique challenges for their managers and executives. They are open 24 hours a day, seven days a week, accept all patients regardless of ability to pay, and serve as the health care safety net for the most vulnerable Rhode Islanders. In addition to medical staff, most hospital employees require high educational achievement and technical skills to perform their jobs. Families throughout Rhode Island depend on well-run hospitals not only for their health, but also for their livelihood and economic welfare.

Rhode Island’s hospitals are committed to the mission of providing quality care. Experienced managers who can improve services in the face of diminishing resources become even more important. The compensation of hospital leaders is carefully set by boards, led by community members, who are charged with attracting and keeping the best leaders. They follow hospital policy and use competitive market data, just as is done for all hospital employee pay. Boards of trustees must be able to set executive compensation at levels sufficient to attract professional leaders who can improve services and quality of care in the highly competitive New England health care market.

Hospital leaders are responsible for the operation and performance of complex, dynamic public service organizations. They are charged with guiding their organizations through the ever-changing health care environment, with its numerous financial, regulatory, and public policy challenges, while always focusing on the core mission of patient care and safety.

We ask that you help Rhode Island hospitals continue to provide quality care in an increasingly competitive marketplace by not hampering their ability to recruit and retain top talent. Our hospitals are proud to care for Rhode Islanders through all stages of life, times of need, and economic conditions. Every year we serve thousands of individuals, keeping our communities healthy, strong and vibrant.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
March 22, 2016

The Honorable Brian Patrick Kennedy  
Chairman, House Corporations Committee  
State House, Room 328  
82 Smith Street  
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island and its members strongly support bill H.7932, sponsored by Representative Christopher Blazejewski. The referenced legislation seeks to eliminate the imposition of patient cost-sharing by insurers for covered mental health and substance use disorder services. The bill also seeks to streamline the collection of insurance patient cost-share amounts by eliminating the use of co-insurance from insurance in the 2018 plan year.

HARI and its members were active participants in the Senate Study Commission on Patient Financial Liability, as well as the OHIC’s efforts to address high patient cost-shares through the Administration Simplification Task Force. However, throughout the meetings of both entities, a recurring theme was the increasing incidence of patients avoiding necessary care due to high out-of-pocket costs. Of great concern to our members is the increase of patients avoiding mental health and substance use disorder care due to higher specialty co-pays under insurance plans. The critical work of the Governor’s Overdose Task Force and other statewide efforts to increase access to mental health and substance use disorder care for patients in need should not be hindered by a patient’s inability to financially meet the co-pay, deductible or co-insurance requirements of their insurance coverage. As a result, HARI and its members are urging the removal of all such patient cost-share amounts from insurance plans for mental health and substance use disorders.

Additionally, our members are seeking a removal of the utilization of co-insurance in all health insurance plans beginning in 2018. The work of the Senate Study Commission and Administrative Simplification Task Force noted there is high consumer confusion with regard to certain cost-sharing mechanisms, such as co-insurance. Co-insurance is calculated as a percentage of the amount of a provider’s claim an insurer will allow to be paid. Co-insurance amounts are determined only after a provider submits a claim to an insurer and the insurer determines the amount of the claim it will allow; after this, a percentage (ex. 20%) is then calculated and billed to the patient as their co-insurance liability amount. Such a complex method is very difficult for providers to determine and collect at the time of service. Submission of a co-insurance bill to a patient months after the services are rendered only adds to patient confusion about payments owed and make collection by providers unlikely.
HARI and its members believe that the removal of the complexity of co-insurance in favor of deductibles and co-payments as a method of collecting patient insurance cost-shares will help streamline the process and help alleviate some patient confusion.

It is for the above reasons that HARI and its members **strongly support** this bill and urge its passage. We welcome the opportunity to work with you, Representative Blazejewski and all interested parties to enhance the care Rhode Islanders receive.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
March 15, 2016

The Honorable Joshua B. Miller  
Chairman  
Senate Health and Human Services Committee  
State House, Room 318  
Providence, RI 02903

Dear Chairman Miller:

The Hospital Association of Rhode Island and its members strongly support your bill, S.2501. The referenced legislation seeks to eliminate the imposition of patient cost-sharing by insurers for covered mental health and substance use disorder services. The bill also seeks to streamline the collection of insurance patient cost-share amounts by eliminating the use of co-insurance from insurance in the 2018 plan year.

HARI and its members were active participants in the Senate Study Commission on Patient Financial Liability, as well as the OHIC’s efforts to address high patient cost-shares through the Administration Simplification Task Force. However, throughout the meetings of both entities, a recurring theme was the increasing incidence of patients avoiding necessary care due to high out-of-pocket costs. Of great concern to our members is the increase of patients avoiding mental health and substance use disorder care due to higher specialty co-pays under insurance plans. The critical work of the Governor’s Overdose Task Force and other statewide efforts to increase access to mental health and substance use disorder care for patients in need should not be hindered by a patient’s inability to financially meet the co-pay, deductible or co-insurance requirements of their insurance coverage. As a result, HARI and its members are urging the removal of all such patient cost-share amounts from insurance plans for mental health and substance use disorders.

Additionally, our members are seeking a removal of the utilization of co-insurance in all health insurance plans beginning in 2018. The work of the Senate Study Commission and Administrative Simplification Task Force noted there is high consumer confusion with regard to certain cost-sharing mechanisms, such as co-insurance. Co-insurance is calculated as a percentage of the amount of a provider’s claim an insurer will allow to be paid. Co-insurance amounts are determined only after a provider submits a claim to an insurer and the insurer determines the amount of the claim it will allow; after this, a percentage (ex. 20%) is then calculated and billed to the patient as their co-insurance liability amount. Such a complex method is very difficult for providers to determine and collect at the time of service. Submission of a co-insurance bill to a patient months after the services are rendered only adds to patient confusion about payments owed and make collection by providers unlikely. HARI and its members believe that the removal of the complexity of co-insurance in favor of deductibles and co-payments as a method of collecting patient insurance cost-shares will help streamline the process and help alleviate some patient confusion.
It is for the above reasons that HARI and its members strongly support this bill and urge its passage. We welcome the opportunity to work with you and all interested parties to enhance the care Rhode Islanders receive.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
April 26, 2016

The Honorable Brian Patrick Kennedy  
Chairman, House Corporations Committee  
State House, Room 328  
82 Smith Street  
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island (HARI) and its members support bill H.8077, sponsored by Representative Raymond Gallison. The referenced legislation seeks to improve and strengthen the Nurse Licensure Compact (NLC). Enacted by Rhode Island in 2008, the Nurse Licensure Compact (NLC) is an agreement with 24 other states to standardize nurse licensure and enable nurses to cross state borders without the cumbersome need to relicense in each state. Our members, and the larger health care system, rely on Rhode Island nurses to provide quality care to all Rhode Islanders.

This bill intends to further improve quality patient care through enhanced uniform licensure requirements, criminal background checks, disciplinary reporting, dispute resolution, and establishment of an interstate governing commission with rulemaking authority. The goal of the NLC is to improve patient care by allowing flexibility of nurse practice, especially with the dawning of new methods of medical practice such as telemedicine and case management crossing state boundaries. According to the National NLC Board, approximately 20,000 Rhode Island nurses were practicing under a multi-state nursing license privilege under the NLC in 2015.

HARI and its members are committed to the state’s efforts to innovate and transform the health care delivery and payment systems. Our members believe passage of the NLC enhancements in this bill will provide for greater care coordination, enhance the use of innovative care models (like telemedicine), end confusing and redundant licensure regulations across state lines, promote compliance with nursing licensure laws, and allow for better response in times of disaster.

It is for the above reasons that HARI and its members support this legislation.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza  
President
March 22, 2016

The Honorable Brian Patrick Kennedy  
Chairman, House Corporations Committee  
State House, Room 328  
82 Smith Street  
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island (HARI) and its members oppose bill H.7880, sponsored by Representative Scott Slater. The referenced legislation would prohibit the temporary employment of non-Rhode Island licensed nurses except under specific circumstances to be defined by the Department of Health through regulation. Our members believe such a restriction will hinder hospitals’ ability to access resources available to hospitals in staffing at critical times to ensure high-quality and affordable health care.

While this bill’s intent is to require the hiring of Rhode Island nurses first, that is what is currently occurring in most instances. However, instances do occur where hospitals must utilize agency nurses—such as due low staffing availability during peak vacation times, or in certain specialty areas where temporary staff are difficult to find. Hospitals must have this flexibility to ensure quality and safe care.

Patient safety is at the center of all staffing decisions made by the caregiving team. Our members strongly believe that health care resources should be used efficiently and effectively to ensure access to quality and affordable care for all. Patient needs can change hour-by-hour and staffing decisions need to be flexible. There will always be a need to improve the support systems and decision-making process, but improvements cannot be achieved by permanently eliminating autonomy to staff appropriately. We endorse staffing models that support care decisions at the point of care.

Hospitals in Rhode Island currently provide their staffing annually to the Department of Health. The members of HARI are working to be more transparent related to nurse staffing since last Assembly session. Some items to note are:

- Nurse staffing from agencies/compact are approximately .4% to 5% of all nurses at hospitals;
- Common reasons for utilizing agency/compact nurses are vacation, holiday/leave of absence, seasonal volume, difficulty filling positions in specialty areas (i.e., operating rooms);
- Agency/compact nurses have the same hospital orientation or a comprehensive orientation including medication policies, emergency and code protocols, and use of electronic medical record systems.
Last year these issues we brought before both houses in an effort to repeal Rhode Island’s participation in the Nurse Licensure Compact (NLC). In response to those efforts, the House enacted Resolution 434 at the end of the 2015 session creating a Special Legislative Commission to Study and Review Rhode Island’s Ongoing Participation in the NLC. To date, the Commission has not yet met. Based off our research above, HARI and its members believe that the work of this Commission could answer many of the questions surrounding the use of agency, travel, and non-Rhode Island licensed nurses.

HARI and its members are committed to the state’s efforts to innovate and transform the health care delivery and payment systems. Our members are working continuously within the greater health care community to innovate, slow the growth of health care costs and improve patient care. Limiting methods for delivering care stifles innovation and shortchanges patients. The evolving changes in health care delivery-and-payment systems reward high-quality patient care and penalize poor care. So it is in the best interest of the hospital, our nurses, and especially our patients, to have adequate staffing.

It is for the above reasons that HARI and its members oppose this legislation.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza
President
Thank you Mr. Chairman and members of the committee for the opportunity to speak on this proposed legislation. I’m Mike Souza, president of the Hospital Association of Rhode Island. The Hospital Association represents eight acute care hospitals, Butler Hospital and the Providence VA Medical Center. HARI and its members oppose this legislation which limits the use of the Nurse Licensure Compact and resources available to hospitals in staffing at critical times to ensure high-quality and affordable health care.

**Staffing at hospitals is safe.** Patient safety is at the center of all staffing decisions made by the caregiving team. And, hospitals believe that health care resources should be used efficiently and effectively to ensure access to quality and affordable care for all.
Patient care is best determined by the caregiving team at the bedside. Patient needs change hour-by-hour. Staffing decisions need to be flexible. There will always be a need to improve the support systems and decision-making process, but improvements cannot be achieved by permanently eliminating autonomy to staff appropriately. We endorse staffing models that support care decisions at the point of care.

Hospitals are committed to health care transformation that improves the health care delivery and payment systems. We are working continuously to innovate, slow the growth of health care costs and improve patient care. Limiting methods for delivering care stifles innovation and shortchanges patients. The evolving changes in health care delivery-and-payment systems reward high-quality patient care and penalize poor care. So it is in the best interest of the hospital, our nurses, and especially our patients, to have adequate staffing.

Hospitals in Rhode Island currently provide their staffing annually to the Department of Health. HARI is working to be more transparent related to nurse staffing since last Assembly session. Some items to note are:
- Nurse staffing from agencies/compact are approximately .4% to 5% of all nurses at hospitals
- Common reasons for utilizing agency/compact nurses are vacation, holiday/leave of absence, seasonal volume, difficulty filling positions (eg. operating rooms)
- Agency/compact nurses have the same hospital orientation or a comprehensive orientation including medication policies, emergency and code protocols, EMR, etc.

THANK YOU and again we oppose this legislation to ensure resources are available to hospitals in staffing at critical times to ensure high-quality and affordable health care.
May 12, 2016

The Honorable Michael J. McCaffrey
Chair
Senate Committee on Judiciary
State House, Room 313
Providence, RI 02903

Dear Mr. Chairman: Re: 16S-2173

As organizations dedicated to the care and protection of patients across Rhode Island, we are asking you to vote in opposition to S-2713, legislation to give law enforcement agencies access to the prescription drug monitoring program (PMP) without a warrant.

The PMP contains information on virtually all scheduled drugs prescribed in Rhode Island by a health care provider, including painkillers, anti-seizure medication, mood stabilizers, diet pills, and sleep aids. Its purpose is to facilitate patient care by limiting overprescribing, and assisting health care providers in recognizing when a patient may be engaging in drug-seeking behavior so health care providers can respond appropriately. It is a tool for health care, not law enforcement. Presently, Rhode Island is one of eighteen states that require law enforcement to obtain a warrant before accessing the records contained within the PMP. This legislation removes that critical requirement.

In doing so, this legislation undermines attempts to deal with the opioid crisis as a medical issue rather than a criminal one. Rhode Island’s focus should be on ensuring doctors can evaluate patients for opioid addiction and get them medical help. Instead, this legislation will leave chronic pain sufferers and other ill Rhode Islanders open to suspicion and investigation based on their legitimate prescriptions, while dissuading some doctors from prescribing medication to their patients out of fear of unfairly being accused of criminal activity.

Rhode Island has a long history of strong patient confidentiality laws that protect patients and doctors from widespread investigation based on out-of-context medical information that law enforcement is not prepared or qualified to interpret. Requiring law enforcement to obtain a warrant before accessing the prescription history of tens of thousands of Rhode Islanders simply provides a judicial check to ensure that investigations are legitimate and evidence-based. Judicial review should remain the standard by which law enforcement is able to access such sensitive information.

There is a very real and urgent need to solve the opioid overdose crisis in our state and to address problems of drug abuse more generally. However, if we value personal privacy between physicians and patients, we cannot, and should not, accomplish that goal by granting warrantless access to the PMP.
It is no more appropriate than allowing police to enter our homes and open our medicine cabinets on demand. S-2713 undercuts efforts to address drug abuse medically, and is inconsistent with the very goals of the PMP itself.

For all these reasons, we respectfully ask that you vote in opposition to S-2713.

Sincerely,

Rhode Island Medical Society
Hospital Association of Rhode Island
Rhode Island Academy of Physician Assistants
Rhode Island Association of Oral and Maxillofacial Surgeons
Rhode Island Dental Association
Rhode Island Health Center Association
Rhode Island Optometric Association
RI Chapter, American College of Physicians
RI Pharmacists Association
RI Society of Anesthesiology
South County Health
Substance Use and Mental Health Leadership Council of Rhode Island
February 3, 2016

The Honorable Joshua B. Miller  
Chairman  
Senate Health and Human Services Committee  
State House, Room 318  
Providence, RI 02903

Dear Chairman Miller:

The Hospital Association of Rhode Island and its members oppose your bill, S.2207. The referenced legislation seeks to require hospitals to post the total payroll and benefits for the top highest compensated employees of each facility. Additionally, it requires hospitals to make a duplicate posting on their websites of transparency information submitted to, and posted by, the Department of Health (HEALTH).

Rhode Island’s hospitals are committed to the mission of providing quality care. Experienced managers who can improve services in the face of diminishing resources become even more important. The compensation of hospital leaders is carefully set by boards, led by community members, who are charged with attracting and keeping the best leaders. They follow hospital policy and use competitive market data, just as is done for all hospital employee pay. Boards of trustees must be able to set executive compensation at levels sufficient to attract professional leaders who can improve services and quality of care in the highly competitive New England health care market.

While our members also have been supportive of transparency in pricing, we oppose the duplicate requirement of this bill for hospitals to also post average charges reported to HEALTH. Reporting to a centralized location within HEALTH allows better opportunity for patients to effectively comparison shop. In addition, the state’s All Payer Claims database (APCD) is going live next week and will have much of the same information. Our members believe a centralized location for standardized information either on the APCD or with HEALTH is the best method for patients to view all average charge data to make better informed decisions about their care and costs. Requiring hospitals to also post the data could lead to confusion with differences in formatting and timeliness of the data as reported by the APCD and HEALTH.

For the reasons detailed above, HARI and its members oppose passage of S.2207. We ask that you help Rhode Island hospitals continue to provide quality care in an increasingly competitive marketplace by not hampering their ability to recruit and retain top talent. We also ask that you help minimize patient/consumer confusion in transparency of average charge reporting by supporting the APCD as a centralized data location.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza  
President
March 8, 2016

The Honorable Brian Patrick Kennedy  
Chairman, House Corporations Committee  
State House, Room 328  
82 Smith Street  
Providence, RI 02903

Dear Chairman Kennedy:

The Hospital Association of Rhode Island and its members support with concern bill H.7708, sponsored by Representative Daniel McKiernan. The bill seeks to do the following: streamline the Utilization Review (UR) process for health insurance claim denials; shift jurisdiction of UR to the Office of Health Insurance Commissioner (OHIC) from the Department of Health (DOH); and establish network adequacy requirements for health insurance plans.

Our members support the removal of second level or internal appeals from the UR process. Such change will make the appeals process move faster and enable providers and patient to receive decisions on denials in a timely manner. However, HARI and its members are deeply concerned with the bill’s move of jurisdiction over UR from the Department of Health to OHIC. Because OHIC is within the Department of Business Regulation, the shifting of UR to OHIC would remove this important healthcare oversight function from the DOH oversight and the Executive Office of Health and Human Services. We believe retaining UR under EOHHS will maintain key coordination for developing successful healthcare reforms, consistent policies and regulations. UR has a medical review component and is related to the public health functions of the Department of Health with regard to managed care oversight and the state’s development of Accountable Entities as part of the Healthcare Innovation reform efforts.

HARI and its members do support the final piece of the bill establishing health insurance network adequacy requirements. With the reforms coming in health care delivery and insurance coverage, ensuring consumers have adequate access to covered providers will be essential. This section of the bill is a necessary step in making sure that consumers are not inadvertently unable to seek needed care and be certain that the provider is within their plan, or that covered providers are available to care to them in their area, as the system undergoes changes in health care delivery and coverage.

We welcome the opportunity to work with you, Representative McKiernan, and all interested parties to enhance the care Rhode Islanders with substance abuse disorders receive.

Thank you for your consideration on this matter.

Sincerely,

Michael R. Souza  
President

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Michael R. Souza  
President

Hospital Association of Rhode Island  
405 Promenade Street – Suite C, Providence, Rhode Island 02908  
p (401) 443-2803  
f (401) 533-9328