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Purpose of this Document

This document is intended to support the **Rhode Island Health Care System Planning (HCSP) Initiative and specifically the Hospital Sector Working Group Discussion for Meeting #1, on September 19th**.

- Please reference the Meeting #1 PowerPoint for an executive summary of problem statements and draft solutions.
- This document provides supporting details on both the problem areas and solutions as discussed in one on ones with working group members.
- These materials should be considered preliminary working documents, in support of Meeting #1. Problem statements and solutions identified here have not yet been confirmed by the working group as a whole.

Additional Details: Problems & Strategies

Problems to Consider

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Priority Level A

#1: Lack of Statewide Health System Oversight, Data Infrastructure, and Long-Term Planning

a) Need for an established, resourced, ongoing process and structure to monitor and maintain community needs, system capacity, rate adequacy and hospital fiscal stability
   - Crisis has not been adequately identified - Unlike Massachusetts, RI hasn't had spectacular failures leading to immediate action.
   - Lack of data collection, appropriate data governance, oversight, and long-term vision to inform this process - re: community needs (considering outmigration of services), system capacity, rate adequacy, hospital fiscal stability
   - Certificate of Need (CON) process isn't working
     - Most proposals are approved, causing unnecessary duplication of services which is diluting hospital volume and increasing operating costs.
     - CON process itself is outdated (e.g. length of time for proposal review, $ thresholds, etc.)
     - Conditions on approvals lack substance and enforcement (e.g., remaining nonprofit, locally owned)
   - Historically RI hospitals have built specialized capacity for new services without sufficient demand to deliver them efficiently detracting from core services and populations, causing financial distress
     - Need to identify services/specialties needed in-state vs those that can be provided by bordering states

b) Lack of transparency of hospital and health system fiscal performance, underlying costs, and payment rates
   - Specific concern regarding lack of transparency and oversight over hospital operating cost and health system expenditures
   - Little insight/acknowledgement of the impact of integrated physician practices on hospital financial performance and operational challenges

c) Some existing regulatory structures to leverage (identified in Legal and Regulatory Framework, February 21, 2023 | Manatt, Phelps & Phillips, LLP)– but insufficiently resourced, lacking "teeth" and not aligned.

d) Lack integrated multi-payor regulatory/oversight processes between EOHHS, OHIC, RIDOH, and OAG.
   - Current regulatory authority structure for health system planning is too dispersed to be effective

e) Insufficient private equity guardrails

f) Limited focus on statewide health equity
   - Impact of hospital financial instability on communities with high Medicaid reliance and reliance on EDs

- Concern regarding hospital compliance with and investment through the Community Benefit requirements – lack of state enforcement mechanisms
- Lack of transparency into disparities in health outcomes by race, ethnicity by hospital
- Lack of coordination across the continuum of care, including with community organizations, social service providers, and others that can ensure people are accessing preventative care

g) Lack of state-level regulatory pathways that incorporate Medicare Advantage – hospital concerns with increasing denials have no recourse

h) Hospital system silos – limited collaboration to identify and disseminate best practices that address system-wide challenges

#2: Reimbursement Not Keeping Pace with Rising Costs

a) Wages and benefits
- Lack of sufficient wages and benefits to encourage retention – specifically a concern when competing with bordering states
- High physician pay subsidies
- Lack of affordable accommodation for residents and the healthcare workforce more broadly
- Cost of medical training is too high

b) Key drivers of rising operating costs
- Payor behaviors – Increasing claims denials and prior authorizations with ongoing arbitrary changes, resulting in high legal fees and operating losses, especially in Medicare Advantage (MA) - MA programs have been a net negative for physicians, compared to traditional Medicare
- Scale – "small/medium" hospitals and health systems by national standards limits efficiency in large part due to high administrative infrastructure costs
- Excessive documentation requirements – EMR systems designed for billing improvements, but reducing staff efficiency
- Increasing cost of medical supplies and drugs
- Overhead (e.g., payment of physician subsidies, legal fees, etc.)

c) Reimbursement limitations, especially Medicaid
- Commercial appears comparable to bordering states (as reported by Manatt Health RI Hospital and Health System Study, March 2024)
- Medicaid rate adequacy (data not available) but substantive concerns noted
- Suppressed reimbursements create high risk of hospital closures

d) Medicaid reimbursement structure
- Not predicable - Highly dependent on supplemental payment components outside of rates (e.g., UPL, DSH, SDPs, GME)

- Not sufficiently leveraging federal match – MCO tax, provider tax opportunity, perception that Rhode Island is leaving federal dollars on the table

e) Negotiated fees
   - Rates and fees are negotiated (for commercial, MA, Medicaid managed care), not set, and can vary substantially based on market power – leaving smaller providers disadvantaged
   - No political will to hold commercial carriers accountable for having a sufficient network. Note, the AG's office planning to release a report in a few weeks demonstrating this issue.
f) Hospital accountability & payment reform
   - Need for hospital accountability for rising operating costs –state fiscal monitoring tied to penalties/incentives, or global budget
   - Global budgeting & AHEAD as potential pathway to accountability
     - Some noted challenges/limitations of value based payments (VBP) and/or global budgets as a solution, such as limited financial support and state capacity for effective planning, adding to existing payer and payment complexity, need for multi-payer participation, concerns regarding risk transfer to financially fragile provider organizations and losses on VBC contracts eliminating operating margins.

#3: Limitations in Investment and Technology

a) Low margins limiting ongoing investments in facilities, fixed assets, IT infrastructure and cybersecurity
   - Hospital facilities in the state are largely out of date and need capital for significant investments to overhaul and remodel
b) Small scale, financial instability limits access to capital/bond markets
c) Challenges of working with small independent insurers who are required to have their own infrastructure, impacting costs and operations, which limits their ability to invest in systems that help hospitals from a data perspective.
d) Regulatory environment
   - Limitations on partnerships across state lines
   - Hospital Conversion Act is arduous and costly, limiting mergers that could bring needed investments
e) Technology gaps
   - Lack of EMR alignment across hospitals and providers
   - Poor communication across providers even using the same EMR system
   - Lack of needed EMR functionality, fair contracting terms
   - EMRs lack clinical-centered design, causing inefficiencies, steep learning curves, etc.
f) Cybersecurity risks causing business continuity risks
   - Reliance on tech means if systems go down, hospitalists can't write orders – all operations stop
   - Lack of thought leaders in cybersecurity – both in state positions and in the hospital systems

- Asymmetric cybersecurity regulatory environment (hospitals have very clear penalties, whereas vendors do not have that same level of regulatory oversight)

Priority Level B

#4: Workforce Challenges

a) Nursing & Tech shortages
   - In the past, nurses generally had a dedicated CNA, now there is one CNA split between 2 or 3 nurses.
   - RN and ancillary staff supply shortages - decreasing percentage of licensed RNs interested in pursuing careers in the medical industry (50% in 2018 down to 38% in 2023 (RI EOHHS, Health Workforce Data Dashboard))
   - Lack of clear and robust career ladder from CNA to LPN or RN – among those with a valid license record with RI, only 8% have gone on to become an RN since 2010 (RI EOHHS, Health Workforce Data Dashboard)
   - Lack of experiential training and apprenticeship programs leaving entry level nursing staff not prepared to work independently, leading to faster burnout and high turnover
   - Limited surgical and diagnostic imaging Technologists and Technicians – only one surgical tech associates programs in the state

b) Lack of hospital wide strategic workforce planning, career path development and implementation – insufficient managerial resources and capacity within hospitals to take advantage of existing state workforce programs and partner with Department of Labor on addressing emerging workforce needs

c) Lack of engagement and partnership between hospital leadership and physicians/specialists

d) Lack of access to physicians/specialists – patients are waiting several months to get an appointment

#5: ED Utilization, Primary Care Capacity and Prevention

a) Lack of sufficient education and awareness campaigns re appropriate use of EDs vs primary care (*checking for data/evidence)*
   - Use of Emergency Departments for non-emergency care for families and children - sore throats, sinus infections, primary care dental needs, etc.

b) Primary care and alternatives (Checking for data/evidence)
   - Lack of access to primary care physicians, causing increased ED utilization, impacting RI's most vulnerable populations the hardest – need for targeted investment in primary care capacity
   - Inadequate leveraging of FQHC system to reduce avoidable ED use - payment model should be an opportunity
   - Most Rhode Islanders cite lack of open alternatives as reasons for using ER for 'non-emergency' care. *(checking for data)*
   - Seriously ill patients are overwhelming EDs and being treated, admitted rather than having the appropriate palliative care consults

c) Behavioral Health & HRSNs

- Lack of HRSN navigators/centralized resources to appropriately support patients frequenting the ED
- Early and pending investments in mobile crisis CCBHC, and community BH alternatives making a difference, must grow/maintain
- ED triage, specifically for patients with behavioral health needs

#6: Length of Stay and Care Transitions

a) Patient Complexity - Higher acuity patients are staying in hospitals longer
b) Community Alternatives
    - Care transitions to post-acute care, LTC, BH care and social services are a challenge
    - Financial stability of alternative community settings are at risk in part due to workforce
    - BH inpatient stays are significantly longer than necessary due to lack of step-down options
    - Long lengths of stay due to lack of nursing home beds and cuts to homecare agencies largely due to reimbursement issues.
c) Lack of sufficient physician training in palliative care extending lengths of stay when individuals should be moved earlier into hospice settings
d) Lack of standardized approach to managing care transitions

Preliminary Strategies & Opportunities to Consider

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Policy and Regulation	Funding and Infrastructure	Payment
Quick Hits		
1. Perform initial analysis & build state infrastructure/capacity for ongoing **Hospital Fiscal Transparency & Performance Monitoring (with equity lens)** ○ Leverage existing EOHHS and RIDOH authority - Ensure mechanism is in place to enable full access to for-profit hospital finances/data. ○ Create baseline analysis/initial dashboard of hospital fiscal stability and operational/efficiency metrics. Metrics and analysis to include disparities in health outcomes by race/ethnicity. ○ Implement data governance for hospital and health system financials that incorporates hospital signoff on measures, data presentation, and interpretation of hospital/health system data. Establish processes to support public access and use of data by providers, partners, researchers. ○ Leverage portion of hospital tax to fund ongoing state infrastructure. 2. Perform initial analysis & build state infrastructure/capacity for ongoing **Statewide Capacity & Needs Assessment** ○ Leverage existing RIDOH authority - Create statewide plan of where/what acute care services are needed, including bed capacity, prioritizing service capacity for vulnerable communities. Potentially leverage/build on Statewide Health Inventory study. ○ Perform baseline analysis to inform short and long-term health system vision, as a prerequisite to infrastructure investment decisions, CON process reforms ○ Leverage portion of hospital tax to fund state infrastructure/capacity for this analysis on an ongoing basis ○ Enhance monitoring and enforcement of **community benefit compliance** – to inform/align with community health needs assessment 3. **Define authority and governance model** to support state oversight and monitoring of **prior authorizations and denials in Medicare Advantage (MA) based on national** best practices (e.g., implement participation conditions on Medicaid, DSNP, delegated authority) 4. Implement policies to **increase RiteShare take-up as a mechanism to maximize employee enrollment in employer sponsored commercial coverage** and lower unnecessary reliance on Medicaid. *(pending initiative)*	5. Establish pathway & funding for **hospital learning collaborative** on best practices in hospital operations (e.g., billing codes, EMR systems, centralized services etc.) ○ Document and share relevant learnings with community partners (e.g., assistance with Medicaid billing) 6. **Seek 1115 Waiver authority and funding** ○ Seek DSHP/CNOM authority for state university health workforce expenditures ○ Potential Uses of funds: ▪ 1) Pay for performance on key measures of hospital operational efficiency/financial improvement ▪ 2) Added support for financially unstable hospitals (NY-like model) – focusing investment on hospitals in at risk communities ▪ 3) infrastructure funds for hospitals participating in global budgeting, plus ongoing funds tied to quality outcomes for participating hospitals 7. **Build state expertise in cyber security**, identify funding opportunities	**8. Medicaid Payment – Step 1** ○ Conduct a **comprehensive hospital & targeted physician/specialist Medicaid rate study** across all DRGs to inform Medicaid rate decision. Begin with hospital DRGs, then assess physician/specialist rates based on priority physician practice areas identified by hospitals ○ **Maintain directed payments/one-time payment mechanisms** to protect hospitals while studies are completed ○ **Leverage hospital tax –** Increase hospital tax in line with CMS rules for existing redistributions of provider taxes to fold back into provider system. Monitor/follow new federal guidance and restrictions 9. **Consider aligning cadence of Medicaid state directed payments** with hospital fiscal year – admin fix for MCOs, OMB, others? 10. **Consider changing Medicaid payment policy to pay on discharge DRG** to align with other payors

Policy and Regulation	Funding and Infrastructure	Payment
Short Term		
11. **Establish a vision for the health care system, and in particular the hospital sector in RI,** informed by the fiscal status of hospitals (#1 above) and the statewide capacity/needs (#2 above). ○ Consider RI specific vs regional capacity, hospital vs. alternative structures, health equity and geographic differences, centralized technology ○ **Consider creating a new, well-resourced state agency to drive strategic healthcare planning,** consolidating responsibility for health systems oversight in executive branch into this agency. 12. **Restructure Oversight of Mergers and Hospital Conversion –** ○ Strengthen Hospital Conversion Act to **more substantially restrict any transition from non-profit to for profit** & implement guardrails on private equity investments that focus on preventing harms and negative outcomes, so that "returns on investment" don't detract from patient care[1] ○ **Reduce regulatory barriers to non-profit mergers and out of state alignments** – as they limit critical operational and fiscal improvements ○ **Reduce administrative burden** of hospital conversion review process. ○ Explore **certificate of public advantage (COPA) to address antitrust concerns[2].** Requires General Assembly action, and dedicated agency 13. **Reform CON Process** ○ **Transform/**enhance CON process to be based on long-term health system vision and needs assessment, relying more heavily on data with input from expert state staff (i.e., only allow applications for services/infrastructure needed as outlined in needs assessment) ○ **Increase $ threshold**, thereby decreasing purchases needing approval as we increase financial monitoring as an alternative. ○ Implement, monitor, and enforce **conditions on approval** to ensure intended outcomes are attained 14. **Implement** authority and governance model to support state oversight and monitoring of **prior authorizations and denials in Medicare Advantage (MA)** inclusive of monitoring processes, resources and structure, **and hold payers accountable.**	15. **Explore resources through Office of National Coordinator (ONC) for Health Information Technology** for cyber security and/or new technology infrastructure – should be available with enhanced match **16. Enhance Hospital EMR functionality & streamline communications within and across EMR systems** ○ **Leverage CMS Information Blocking and Interoperability & Patient Access Rule** – conditions of participation in Medicaid, Medicare – to require EMR vendors to provide needed/federally required functionality to streamline communications. (combine with clinically centered) ○ **Find a funding pathway to** clinically centered EMR investment (rather than billing centered) ▪ **Potential sources of funds**: State bond issuance, braided federal grant funds, EPIC, Brown University, other? ▪ **Tie funding** to multi-year participation in AHEAD global budget.	17. **Medicaid Payment – Step 2** ○ **Adjust Medicaid payment rates** based on results of comprehensive rate study, comparative to Medicare, other states ○ **Leverage increases to hospital tax** -represents Medicaid share of increase, without any added state budget (if allowable). ○ **Transition state directed payment, other one-time hospital payment mechanisms into rate adjustments** – predictable source of funds ○ **Consider tiered/differential payments** tied to participation in AHEAD or other pay for performance goals (fiscal monitoring/quality measures) 18. **AHEAD model/Global Budgeting Supports** - incorporate additional infrastructure supports for hospitals to support this model (see funding and infrastructure solutions). **Hold solvency funds aside** for participating hospitals in case of financial issues *(pending initiative)*

[1] Note, what defines private equity continues to evolve – need flexibility to ensure that any statutory or regulatory reform can be adequately leveraged to address new and changing actors

[2] Note, COPAs enable officials allow hospitals to merge if they determine the likely benefits from a particular merger outweigh any disadvantages from reduced competition and increased consolidation. States often impose various terms and conditions on COPA recipients intended to mitigate harms from a loss of competition, including price controls and rate regulations, mechanisms for sharing cost savings and efficiencies, and commitments about certain contractual provisions between hospitals and commercial health insurers (Federal Trade Commission, 2022).

Policy and Regulation	Funding and Infrastructure	Payment
Longer Term		
19. Based on outcomes of statewide capacity/needs assessment (and fiscal status of hospitals), **consider alternative community capacity options** for specific geographies ○ E.g., Consider **Free Standing EDs (FSEDs)** –partnered with nearby hospitals and supported with seamless transport/transitions for high acuity patients. Explore regulatory framework – conflicting views on this approach 20. State strategy to **address drug costs and PBN model** (e.g., ref CMS max fair prices (MFPs) to set UPLs)	**21.** Could **consider a single statewide EMR vendor** – pros and cons noted. 22. **Consider State bond issuance** to provide infrastructure support for IT and facilities, tied to financial reporting and efficiency metrics to ensure return on investment.	23. Consider **an all-payor standardized rate** for hospital services, based on the Maryland model. 24. Negotiate **lower commercial rates/hospital payments for state employee health plan, use state savings to increase Medicaid rates** which are matchable – resulting in a net win for hospitals 25. Consider **increasing Medicaid hospital and physician rates to be one to one with Medicare** to improve inequities in access for Medicaid patients.

Policy and Regulation	Funding and Infrastructure / Payment
Cross Sector Opportunities: Workforce	
26. **Tie free medical education** (CCRI & other) **to in state needs** – require those receiving in state education to work in RI for X yrs. **27.** Create pathways (regulatory, payment) for **virtual nursing** **28. Consider requiring entities to enter Labor Peace Agreements to receive Medicaid funding** – allowing unions to fight together/on behalf of hospitals for higher wages.	29. Develop **paid nursing apprenticeships** on night shifts for senior nursing students – may need to address credit requirement challenges with accreditors. 30. Summer earn while you learn: **Utilize CCRI nursing faculty to provide on-site hospital training for new nursing hires/recent grads** for hospitals with shortages/without capacity to provide appropriate oversight/training needed in the first 3 months of a nursing career. **31. Support targeted gaps in hospital workforce** ○ Implement programs (scholarship/incentive-based?) to **encourage more diagnostic imaging and medical lab technologists** ○ **Establish additional Surgical Technologist Associate Programs** in the area – currently only one program at NEIT

Policy and Regulation	Funding and Infrastructure	Payment
Other Sector Opportunities		
Primary Care		
32. Rebuild primary care capacity, infrastructure and incentives to create urgent care within practices. **33. Loan forgiveness for primary care physicians to address shortage** **34. Evaluate the role of community health centers** (for example, FQHCs) given their locations and patients they serve, they can address access from a health equity perspective effectively.	**35. Implement AI Scribes to reduce documentation burden for PCPs**	36. **Invest in Primary Care:** Hospitals control the majority of primary care, but don't have the margins to support. o State could play a role in taking the burden off hospitals to support primary care and ensure the money stays within primary care. 37. Move primary care payment to capitation model to allow **stable funding to support base operations coupled with incentives to reduce utilization** that they can control, like ED utilization.
Behavioral Health		
38. Consider additional intermediate care facilities, specifically ICF/IDs to bridge the transition from inpatient to community settings. 39. Open a **small stabilization/community discharge unit in Butler** – can be interim or partial solution to the lack of step-down options but ultimately need additional ICF capacity. **40. Expansion of BH disciplines with evidence-based practices –** seek federal match to invest in innovative BH workforce solutions.		41. **Maintain/add funding for mobile crises** and community based intensive care program and CCBHCs – these are making an impact 42. Create financial incentives for **additional BH support/community providers in Northern RI** – build on CCBHC requirements? **43. Add another BH-link** in the southern part of state
Health Related Social Needs (HRSN)		
44. Central patient navigator for HRSN providers to refer patients with SDOH needs who are returning to hospitals daily – deepen hospital-HEZ relationships, identifying common goals and utilize/build on HEZ health referral pathway project		
Long Term Care & Healthy Aging		
45. Develop/invest in/ensure regulatory pathways for **innovative alternative post-acute care models**[3] **46.** Create **standardized model for care transitions management**	**47. Retooling of Eleanor Slater Hospital** to a true long term acute care hospital (LTACH) with a modernized facility to treat medically complex patients *(pending initiative)*	

[3] Reference innovations at Kent Hospital - Units that specialize in care of the elderly (ACE@Kent) have demonstrated shorter length of stays, fewer transfers to post-acute units (SNF), and lower re-admission rates; hospitalization at home (Kent@Home) has demonstrated similar impact on healthcare utilization when compared to a traditional hospital setting.