RI Health Care System Planning - Hospitals Workgroup

Meeting #1: Discussion of Hospital Challenges & Potential Solutions

September 19, 2024

Note: 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.

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Co-Chair Introductions

Meeting Norms

- Please use the "raise hand" feature to indicate you'd like to speak
- We welcome use of the chat for comments or questions that **do not** require immediate attention
- Note, the chat will be used as a reference for questions, comments, and considerations to be addressed following the meeting but will not be actively monitored, as to not detract from discussion
- Be concise in your comments to allow time for others to contribute
- Mute your microphone when not speaking

This meeting is being recorded to ensure all thoughts and recommendations are appropriately captured.

Agenda

Topic	(Time 90 mins)
I. Background & Context • Working Group Participants • Status of Work • Goals for Today • Principles • Questions on RI Hospital Sector Starting Point (Appendix 1)	15 Minutes
II. Confirm Draft Problem Statements & Priorities* • Review/refine/confirm the list of Problems/Challenges • Review/refine/confirm the classification of Priorities (A & B) to address	30 Minutes
III. Introduce & Develop Preliminary Strategies & Opportunities* • Review preliminary draft of potential strategies/opportunities • Tackle each of the three "A Priority" Challenges (~10 minutes each)	40 Minutes
IV. Next Steps	5 Minutes

* See Meeting #1 Appendix 2. Detailed Problem Statements & Preliminary Solutions (Word Doc, separate attachment) for additional details. Appendix provides detail into all draft problem statements and solutions.

Note: We plan to briefly discuss slides in this section at the meeting, prioritizing time on Goals & Principles

I. Background & Context

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Purpose & Goals - Health Care System Planning (HCSP) Goals

- Ensure **solvency** of the health care system
- Foster an **integrated delivery system that coordinates care** across the health care continuum focused on population health, care transitions, and patient-centered care
- Ensure **access to affordable, quality, easy to navigate, and comprehensive care**
- Ensure **health equity and reduce disparities** in access and outcomes
- Incentivize **investments in system transformation** to promote innovation
- Strengthen **preventive, and primary physical & behavioral health services** to maintain appropriate utilization & promote efficiencies
- Invest in efforts to address the **social factors that impact health**
- Establish state infrastructure to **oversee health system performance**, improvement, and equity, as well as promote transparency

Workgroup Charge and Meeting Schedule

- **Workgroup Charge:**
  - Provide critical input regarding the Hospital Sector's strengths, services gaps, challenges, and strategic opportunities to enhance access, quality, equity, and performance

- **Meeting Schedule:**
  - Workgroup Meeting #1: Hospital Sector Challenges & Draft Solutions (Today)
    - Objective: To confirm challenges impacting the RI hospital sector and discuss potential strategies and solutions
  - Workgroup Meeting #2: Discussion and Prioritization of Strategic Opportunities (Oct 17th 2:00-3:30)
    - Objective: Review, discuss, and prioritize emerging strategic opportunities to leverage identified strengths and address challenges.

Working Group Participants

Hospital Sector Working Group Facilitators, Staff, and Members

Facilitators

Chair: Secretary Rick Charest (EOHHS)
Community co-facilitator: John Fernandez (Lifespan)

Assistant Secretary Ana Novais (EOHHS)
Commissioner Cory King (OHIC)
Director Matt Weldon (DLT)

Staff

Lead Staffperson: Marti Rosenberg (EOHHS)

Rick Brooks (EOHHS)
Fernanda Lopes (RIDOH)
Mike Dexter (RIDOH)

Workgroup Members

Hospital Leadership

- Mike Wagner (CNE)
- Mike Souza (Landmark)
- Mary Marren (CNE/Butler)
- Aaron Robinson (South County Health)
- Lou Giancola (South County, retired)
- Ara Milette (Lifespan)
- Cedric Priebe (HIT Steering Committee/ Lifespan)
- Lisa Tomasso (HARI)

Subject Matter Experts (SMEs)

- Martha Wofford (BCBS of RI)
- Attorney General Neronha
- Sam Salganik (RIPIN)
- Linda Katz (Healthcare Coalition, retired)
- Marie Ganim (OHIC Commissioner, retired)
- Al Charbonneau (RIBGH)
- Jane Hayward (RIF, retired)
- Pat Crowley (AFL-CIO)
- Lynn Blais (UNAP)
- Susan Jacobsen (Thundermist Health Center, HEZ)
- Rosemary Costigan (CCRI)
- Diana Franchitto (Hope Health)
- Stacy Paterno (RIMS)
- Mukesh Jain (Brown Medical School)
- Gerry Goulet (Health Policy Analytics LLC)
- Michelle Sears (NHPRI)
- Anusha Venkataraman (ONE Central Providence, HEZ)

Status of Work

To date, we have formally interviewed 86% of working group participants[1], coordinated with chairs and facilitators, and met weekly with state staff to inform this work

Interviewed Workgroup Participants

- We heard from:
  - 7 of 8 members of hospital leadership
  - 14 of 17 subject matter experts
- Additionally, met with all facilitators and state staff

Conducted a National Landscape Review

- To inform problem areas and their potential solutions

Refined Problem Statements[2] and Priority Areas

- These are draft and are expected to be updated as additional information is collected

Developed Initial List of Strategies & Opportunities

- These are preliminary and require additional input from the working group to be refined and prioritized

1. Excluding EOHHS & RIDOH State staff
2. Note that these reflect the makeup of the workgroup and learnings from national and local landscape reviews, thus are not necessarily representative of all topics/concerns

Goals for Today

By the end of today's meeting, we will have confirmed Hospital Sector problem statements and introduced initial set of potential strategies and solutions to address priority challenges

Confirm Working Group Principles	• Discuss and confirm draft set of principles that will drive us toward solutions.
Address Questions on Baseline Data on RI Hospital Sector	• Discuss any questions on the RI Hospital Sector Starting Point data and areas needing additional data collection and study
Confirm Draft Problem Statements/Challenges	• Review/refine/confirm the list of Problems/Challenges • Review/refine/confirm the priorities to address as a working group
Introduce & Develop Strategies to Address Key Challenges	• Review preliminary draft of potential strategies/ opportunities beginning with those that address priority problems

Working Group Principles

Working Group Principles will guide the process and products of the working group to ensure the overarching goals set by the RI Health Care System Planning Initiative are achieved.

1. Promote **equitable, high quality, affordable access to healthcare for all** individuals and communities
2. **Focus on solutions** - avoid too much study, identify actions
   - **Prioritize** – identify and focus on the highest priority items
   - **Don't recreate the wheel** – build on existing capacity, learnings, expertise, wherever possible
3. **Data Informed** decisions - some may need to be "longer term" to enable access to better data
   - Propose some **quick fixes** to ensure things don't "break" while longer cycle, data driven decisions are underway
4. **Stay in the hospital sector "lane"** - but identify cross cutting and/or overlapping priorities that need to be tackled in other workgroups.
   - **System and statewide lens for solutions** - not what one hospital should do but what the state, the system as a whole should do
5. **Maximize federal participation –** leverage match, enhanced match, whenever possible.
   - Collectively aim to **keep healthcare revenues in the healthcare sector**

For Discussion:

- *What else?*
- *Any edits or suggestions?*

RI Hospital Sector Starting Point & National Landscape Review

Reminder:

A. **Overview:** Hospital Sector Overview & Fiscal Performance, Local Starting Point

B. **Payment:** Commercial & Medicaid Payment, Local Starting Point

C. **Investment:** Medicaid Payment & Investment Strategies, National Learnings

D. **Transparency & Oversight:** National Learnings & Local Starting Point

E. **Workforce & EMR:** Local Starting Point

For Discussion:

- *Based on your prior review, are there any questions that need to be addressed?*
- *Anything missing – facts you need to inform recommendations?*
- *Anything misstated or misinterpreted that may impact decision-making?*

II. Confirm Draft Problem Statements & Priorities

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Confirm Draft Problem Statements & Priorities

- **Today's Objectives**
  - Review/refine/confirm the list of Problems/Challenges
  - What did we miss? Misstate or mis-interpret?
  - Review/refine/confirm the classification of Priorities (A & B) to address as a working group

Note, these problems and challenges reflect the makeup of this working group and thus are not necessarily representative of all topics/concerns.

Draft Problem Statement Summary* – Priority A

Problem Area	Sub-Categories	Key Elements Noted by Participants*
Priority A Problem Areas		
#1: Lack of Statewide Health System Planning	**Statutory & Regulatory Framework**	Lack of **statewide health system data collection and planning** process
		Crisis has not been adequately identified
		Lack of **multi-payor strategy and regulatory oversight** *(including Medicare Advantage)*
		Limited **private equity guardrails**
		Limited focus on **statewide health equity**
	Fiscal Monitoring & Oversight	Lack of **hospital fiscal transparency/monitoring** *(including carrots/sticks)*
#2: Reimbursement Not Keeping Pace with Rising Costs	**Wages & Benefits**	**Reimbursement as it relates to wages** *(pay, residency costs, cost of living)*
	Other Hospital Administration Operations	**Overhead** *(legal fees/claims denials, malpractice, physician subsidies, etc.)*
		Claims **denials and prior authorizations** *(especially Medicare Advantage)*
		Medical supplies, **drug costs**
	Payment & Reimbursement	Not **maximizing federal match** *(e.g., hospital tax, MCO tax)*
		Payer mix *(heavy Medicaid, high Medicare Advantage penetration)*
		Reimbursement (especially Medicaid)
		Negotiated fees *(inconsistent market power of hospitals)*
	VBP	**Payment Reform** *(need for global budgets, concerns that VBP may not be working)*
#3: Limitations in Investment & Technology	**Access to Capital**	**Insufficient margins** to generate capital for investments
		Limited access to **capital markets**/capital improvements
		Regulatory constraints to market consolidation *(especially across borders)*
		Size/scale limitations *(challenging to manage investments as "small " systems)*
	Technology	Lack of **aligned, consistent EMR**
		Lack of **clinical-centered EMR design**
		Cyber Security Risks

* See Meeting #1 Appendix 2. Detailed Problem Statements & Preliminary Solutions (Word Doc, separate attachment) for additional details. Appendix provides detail into all draft problem statements and solutions.

Draft Problem Statement Summary* – Priority B

Problem Area	Sub-Categories	Key Elements Noted by Participants*
Priority B Problem Areas		
#4: Workforce	**Nursing Shortages**	Cuts to **CNA positions**
		RN and ancillary staff shortages
		Lack of clear and **robust career ladder** from CNA to LPN or RN
		Limited **hands-on training/apprenticeship opportunities** *(leading to faster burnout)*
	Strategic Workforce Planning	Limited hospital wide workforce planning, career path development, & **utilization of state workforce programs**
	Physician Partnership	Lack of engagement and **partnership between hospital leadership and physicians**/specialists
#5: ED Utilization, Primary Care Capacity and Prevention	**Education**	Insufficient **ED Education**/Awareness
	Primary Care/Alternatives	Lack of **Primary Care Capacity**/ Investment in primary care
		Inadequately **leveraging FQHCs** to reduce ED use
		Urgent Care, ED locations
	Behavioral Health & HRSN	Lack of **HRSN navigators**/supports
		Early and pending investments in **CCBHC and mobile crisis** - community BH alternatives
		ED Triage & BH needs
#6: Length of Stay and Care Transitions	**Patient Complexity**	**High acuity patients** /long lengths of stay
	Community Alternatives	Financial fragility of **community settings** - lack of home care workforce
		Lack of **BH step down** options (especially ICF/IDs)
		Lack of **nursing home beds**
	Physician Training	Lack of sufficient **palliative care training**
	Discharge Planning	Lack of standardized approach to **managing care transitions**

* See Meeting #1 Appendix 2. Detailed Problem Statements & Preliminary Solutions (Word Doc, separate attachment) for additional details. Appendix provides detail into all draft problem statements and solutions.

Breakout Group Discussions

- Reference slides 13-14 in your meeting materials
- **Discussion Questions:**
    1. What is your #1 priority problem/challenge for this working group?
    2. Is this problem/challenge appropriately captured and prioritized on slides?
    3. What specific additions or revisions would you suggest?
- *You will have 7 minutes in small groups to discuss*

III. Introduce & Develop Preliminary Strategies & Opportunities

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Introduce & Develop Strategies and Opportunities

- **Today's Objectives**
  - Review preliminary draft of potential strategies/opportunities
  - Tackle each of the three "A Priority" Challenges (~7 minutes each)
  - Are we missing any potential strategies/opportunities. Did we misstate any?
  - Any relevant examples of strategies from other states that aren't reflected?
  - Any experts/SMEs we should engage here?

Note, these strategies and opportunities reflect the makeup of this working group and thus are not necessarily representative of all potential solution pathways.

Strategies & Opportunities #1: Lack of Statewide Health System Planning

Problem Area	Time	Potential Strategies
Priority A Problem Area		
#1: Lack of Statewide Health System Planning	**Quick Hits**	**#1 Build state Infrastructure/capacity for ongoing Hospital Fiscal Transparency & Performance Monitoring** ○ Leverage existing EOHHS and RIDOH authority. Incorporate private equity (PE) oversight and management. ○ Leverage hospital tax to fund state infrastructure for transparency work, rate study, capacity/needs assessment on an ongoing basis. ○ Begin baseline analysis - hospital reporting, accountable to operational/efficiency metrics. ○ Seek CMS authority to tie fiscal performance metrics to payment incentives – leverage 1115- VAPAP like model. **#2 Increase state monitoring of prior authorizations and denials**, utilization review act – specifically for Medicare Advantage **#4 Perform initial analysis & build state capacity for ongoing Statewide capacity & needs assessment** ○ Perform baseline analysis as prerequisite to infrastructure investment decisions ○ Statewide plan of where/what acute care services are needed, including bed capacity, prioritizing the re-capitalization of services for vulnerable communities. Potentially leverage Statewide health inventory study ○ Build state infrastructure/capacity for this analysis on an ongoing basis – leverage hospital tax to fund state infrastructure **#5** Establish pathway & funding for **hospital learning collaborative** on best practices in hospital operations (e.g., billing codes, EMR systems, etc.) **#7 Medicaid Payment – Step 1** ○ **Conduct a comprehensive Medicaid rate study** across all DRGs to inform Medicaid rate decision. Begin with hospital DRGs, then assess physician/specialist rates ○ **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.
	Shorter Term	**#10 Restructure Oversight of Mergers and Hospital Conversion** ○ **Strengthen Hospital Conversion Act** to allow for non-profit hospitals only and prevent private equity investments so that returns on investment don't detract from patient care. ○ **Reduce regulatory restrictions on mergers and out of state alignment** – substantially limits access to capital **#11 Reform CON Process** ○ **Move up the bar on financial monitoring** – rather than regulating service delivery. ○ **Transform/enhance CON process** to be more data driven, based on long-term health system vision and needs assessment **#12 Create policy restrictions on prior authorizations and denials**, utilization review act – specifically for Medicare Advantage (build on existing commercial processes) **#13** Enhance monitoring and enforcement of **community benefit compliance** **#17 Seek 1115 Waiver authority and funding for** match on health expenditures used to align health workforce resources with hospital/community needs. Leverage added match to fund: ○ 1) fiscal support for at risk hospitals meeting financial reporting/transparency requirements (VAPAP-like model) ○ 2) infrastructure dollars to implement global budgeting (prior to global budgeting "go live" or early in implementation), and ○ 3) ongoing infrastructure dollars tied to quality outcomes for hospitals participating in global budgeting.
	Longer Term	**#27** Develop/invest in/ensure regulatory pathways for **innovative alternative post-acute care models** **#28 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

Strategies & Opportunities #2: Reimbursement *vs* Rising Costs

Problem Area	Time	Potential Strategies
Priority A Problem Area		
#2: Reimbursement Not Keeping Pace with Rising Costs	**Quick Hits**	**#1 Build state Infrastructure/capacity for ongoing Hospital Fiscal Transparency & Performance Monitoring** ○ Leverage existing EOHHS and RIDOH authority. Incorporate private equity (PE) oversight and management. ○ Leverage hospital tax to fund state infrastructure for transparency work, rate study, capacity/needs assessment on an ongoing basis. ○ Begin baseline analysis - hospital reporting, accountable to operational/efficiency metrics. ○ Seek CMS authority to tie fiscal performance metrics to payment incentives – leverage 1115- VAPAP like model. **#5** Establish pathway & funding for **hospital learning collaborative** on best practices in hospital ops (e.g., billing codes, EMR systems etc.) **#7 Medicaid Payment – Step 1** ○ **Conduct a comprehensive Medicaid rate study** across all DRGs to inform Medicaid rate decision. Begin with hospital DRGs, then assess physician/specialist rates ○ **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. **#8** Consider **aligning cadence of Medicaid state directed payments** with hospital fiscal year – admin fix for MCOs, OMB, others? **#9** Consider **changing Medicaid payment policy to pay on discharge DRG** to align with other payors
	Shorter Term	**#14 Tie free medical education** (CCRI & others) **to in state needs;** require those receiving in-state education to work in RI for X yrs. **# 17 Seek 1115 Waiver authority and funding for** match on health expenditures used to align health workforce resources with hospital/community needs. Leverage added match to fund: ○ 1) fiscal support for at risk hospitals meeting financial reporting/transparency requirements (VAPAP-like model) ○ 2) infrastructure dollars to implement global budgeting (prior to global budgeting "go live" or early in implementation), and ○ 3) ongoing infrastructure dollars tied to quality outcomes for hospitals participating in global budgeting. **#24 Medicaid Payment – Step 2:** ○ Adjust Medicaid payment rates Based on results of comprehensive rate study, comparative to Medicare, other states ○ Leverage increases to provider tax - represents Medicaid share of increase, without any added state budget (if allowable). ○ Transition 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/measures) **#25 Medicaid Payment – Step 3** ○ Conduct targeted **physician/specialist rate study** based on priority physician practice areas identified by hospitals **#26 AHEAD model/Global Budgeting** - incorporate additional infrastructure supports for hospitals to support this model
	Longer Term	**#30** State strategy to address drug costs and PBN model (e.g., ref CMS max fair prices (MFPs) to set UPLs) **#27 Medicaid Payment – Step 4:** Address physician/specialist rates – based on results of rate study (reference step 3) **#29 -** Expansion of BH disciplines within EBPs – seek federal match to invest in innovative BH workforce solutions **#35** Consider **an all-payor standardized rate** for hospital services, based on the Maryland model **#36** Negotiate **lower commercial rates for state employee health plan**, use state savings to **increase Medicaid rates** which are matchable – resulting in a net win for hospitals

Strategies & Opportunities #3: Limited Investment & Technology

Problem Area	Time	Potential Strategies
Priority A Problem Area		
#3: Limitations In Investment & Technology	**Quick Hits**	**#4 Perform initial analysis & build state capacity for ongoing Statewide capacity & needs assessment** ○ Perform baseline analysis as prerequisite to infrastructure investment decisions ○ Statewide plan of where/what acute care services are needed, including bed capacity, prioritizing the re-capitalization of services for vulnerable communities. Potentially leverage Statewide health inventory study ○ Build state infrastructure/capacity for this analysis on an ongoing basis – leverage hospital tax to fund state infrastructure **#5** Establish pathway & funding for **hospital learning collaborative** on best practices in hospital ops (e.g., billing codes, EMR systems etc.) **#6 Build state expertise in cyber security**, identify funding opportunities
	Shorter Term	**#10 Restructure Oversight of Mergers and Hospital Conversion** ○ **Strengthen Hospital Conversion Act** to allow for non-profit hospitals only and prevent private equity investments so that returns on investment don't detract from patient care. ○ **Reduce regulatory restrictions on mergers and out of state alignment** – substantially limits access to capital **#11 Reform CON Process** ○ Move up the bar on **financial monitoring** – rather than regulating service delivery. ○ **Transform/**enhance CON process to be more data driven, based on long-term health system vision and needs assessment, relying more heavily on data with input from expert state staff **#15** Create pathways (regulatory, payment) for **virtual nursing** **# 17 Seek 1115 Waiver authority and funding for** match on health expenditures used to align health workforce resources with hospital/community needs. Leverage added match to fund: ○ 1) fiscal support for at risk hospitals meeting financial reporting/transparency requirements (VAPAP-like model) ○ 2) infrastructure dollars to implement global budgeting (prior to global budgeting "go live" or early in implementation), and ○ 3) ongoing infrastructure dollars tied to quality outcomes for hospitals participating in global budgeting. **#18 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 **#19 EMR enhancements – Leverage CMS Information Blocking and Interoperability & Patient Access Rule** – conditions of participation in Medicaid, Medicare – require EMR vendors to provide functionality **#23 State bond issuance** to provide infrastructure support for IT and facilities, tied to global budgeting.
	Longer Term	**#31 Find a funding pathway to** Clinically (rather than billing) centered EMR investment ○ **Potential sources of funds**: State bond issuance, braided federal grant funds, EPIC, Brown, other? ○ Tie funding to multi-year participation in AHEAD global budget. ○ Hold solvency funds aside in case hospitals run into financial issues while participating **#32** Could consider a **single statewide EMR vendor** – pros and cons noted.

Breakout Group Discussions

- Reference slides 17-19 in your meeting materials
- **Discussion Questions:**
    1. What is the #1 strategy you want this working group to consider?
    2. Is the strategy/opportunity appropriately captured and defined on these slides?
    3. What specific additions or revisions would you suggest?
- *You will have 7 minutes in small groups to discuss*

Strategies & Opportunities – Priority B Problem Areas

Problem Area	Time	Potential Strategies
Priority B Problem Areas – *to be discussed if time allows*		
#4: Workforce	**Quick Hits**	n/a
	Shorter Term	**#14 Tie free medical education** (CCRI, others) **to in state needs** – require those receiving in state education to work in RI for X yrs. **#15** Create pathways (regulatory, payment) for **virtual nursing** **#16 Consider requiring entities to enter Labor Peace Agreements to receive Medicaid funding** – allowing unions to fight together/on behalf of hospitals for higher wages. **#17 (excerpt) Seek 1115 Waiver authority and funding for:** ○ Match on health expenditures used to align health workforce resources with hospital/community needs. **#21** Develop **paid nursing apprenticeships** on night shifts for senior nursing students – may need to address credit requirement challenges with accreditors. **#22** 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.
	Longer Term	**#31 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, other? ○ Tie funding to multi-year participation in AHEAD global budget. ○ Hold solvency funds aside in case hospitals run into financial issues while participating **#32** Could consider a single statewide EMR vendor – pros and cons noted. **#33 Establish additional Surgical Technologist Associate Programs** in the area – currently only one program at NEIT
#5: ED Utilization, Primary Care Capacity and Prevention	**Quick Hits**	**#3 Central patient navigator for HRSN providers** to refer patients with SDOH needs who are returning to hospitals daily –build on HEZ?
	Shorter Term	**#14 Tie free medical education** (CCRI & others) **to in state needs;** require those receiving in-state education to work in RI for X yrs.
	Longer Term	**#28 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 **#29** Create **standardized model for care transition management**
#6: Length of Stay and Care Transitions	**Quick Hits**	**#2 Increase state monitoring of prior authorizations and denials,** utilization review act – specifically for Medicare Advantage **#3 Central patient navigator for HRSN providers** to refer patients with SDOH needs who are returning to hospitals daily –build on HEZ?
	Shorter Term	**#12 Create policy restrictions on prior authorizations and denials**, utilization review act – specifically for Medicare Advantage (build on existing commercial processes) **#15** Create pathways (regulatory, payment) for **virtual nursing** **#20 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)
	Longer Term	**#27** Develop/invest in/ensure regulatory pathways for **innovative alternative post-acute care models** **#29** Create **standardized model for care transition management**

Strategies & Opportunities – Other Sectors

Problem Area	Sector	Potential Strategies
Priority A Problem Areas		
#1: Lack of Statewide Health System Planning	**Primary Care**	**#39 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.
#2: Reimbursement Not Keeping Pace with Rising Costs	**Primary Care**	**#38 Loan forgiveness for primary care physicians to address shortage** **#41 Invest in Primary Care:** The hospitals control the majority of primary care, but don't have the margins to support. **State could play a role in taking the burden off hospitals to support primary care** and ensure the money stays in within primary care. **#42** - 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.
Priority B Problem Areas		
#5: ED Utilization, Primary Care Capacity and Prevention	**Primary Care**	**#37** Rebuild primary care capacity, infrastructure and **incentives to create urgent care within practices**. **#38 Loan forgiveness for primary care physicians to address shortage** **#39 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. **#40 Implement** AI Scribes to reduce documentation burden **for PCPs** **#41 Invest in Primary Care:** The hospitals control the majority of primary care, but don't have the margins to support. **State needs to take the burden off hospitals to support primary care** and ensure the money stays in within the primary car arena. **#42** 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	**#46 Maintain/add funding for mobile crises** and community based intensive care program and CCBHCs – these are making an impact **#47** Create financial incentives for **additional BH support/community providers in Northern RI** – build on CCBHC requirements? **#48 Add another BH-link** in the southern part of state
#6: Length of Stay and Care Transitions	**Behavioral Health**	**#43** Consider additional intermediate care facilities, specifically ICF/IDs to bridge the transition from inpatient to community settings **#44** Open 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. **#45** Expansion of BH disciplines within EBPs – **seek federal match to invest in innovative BH workforce solutions** **#46 Maintain/add funding for mobile crises** and community based intensive care program and CCBHCs – these are making an impact

Review Next Steps

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Next Steps

- **Friday September 27th**
  We will send meeting minutes, revised problem statements/potential solutions & committee survey
- **Homework due Friday, October 4th**
  - Respond to Jess' survey – what are your top five priority strategies (from the revised list), did we miss anything?
  - Send us any/all feedback: problem statements, data/research needs, SMEs, additional ideas
- **Next Meeting: October 17th 2:00-3:30 ET**
  - Focus of next meeting will be on **recommended actions and strategic opportunities**

Any questions, feedback or ideas to share? Email/Text/Call

Jess Brown, jbrown@faulknerconsultinggroup.com (401)-330-8155

Deb Faulkner, deb@faulkerconsultinggroup.com (401)-486-3700

Note: We plan to reference this section as needed, suggest participants review in advance, raise any questions about the data before we dive to challenges and solutions and refer to as needed during the discussion.

Appendix #1

RI Hospital Sector Starting Point & National Landscape Review

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Appendix #1 Materials

A. **Overview:** Hospital Sector Overview & Fiscal Performance, Local Starting Point

B. **Payment:** Commercial & Medicaid Payment, Local Starting Point

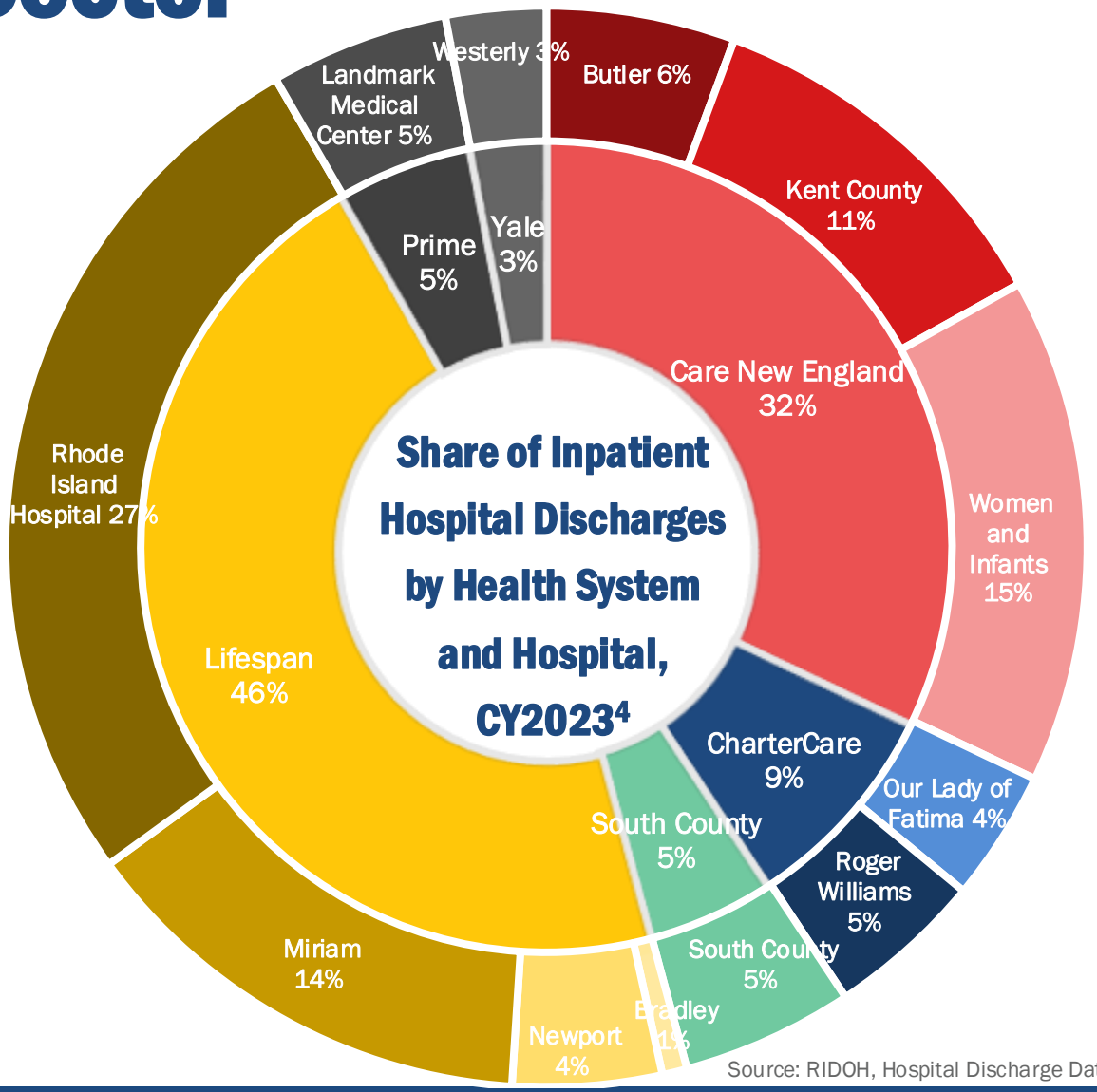
C. **Investment:** Medicaid Payment & Investment Strategies, National Learnings

D. **Transparency & Oversight:** National Learnings & Local Starting Point

E. **Workforce & EMR:** Local Starting Point

A. Overview - RI Hospital Sector

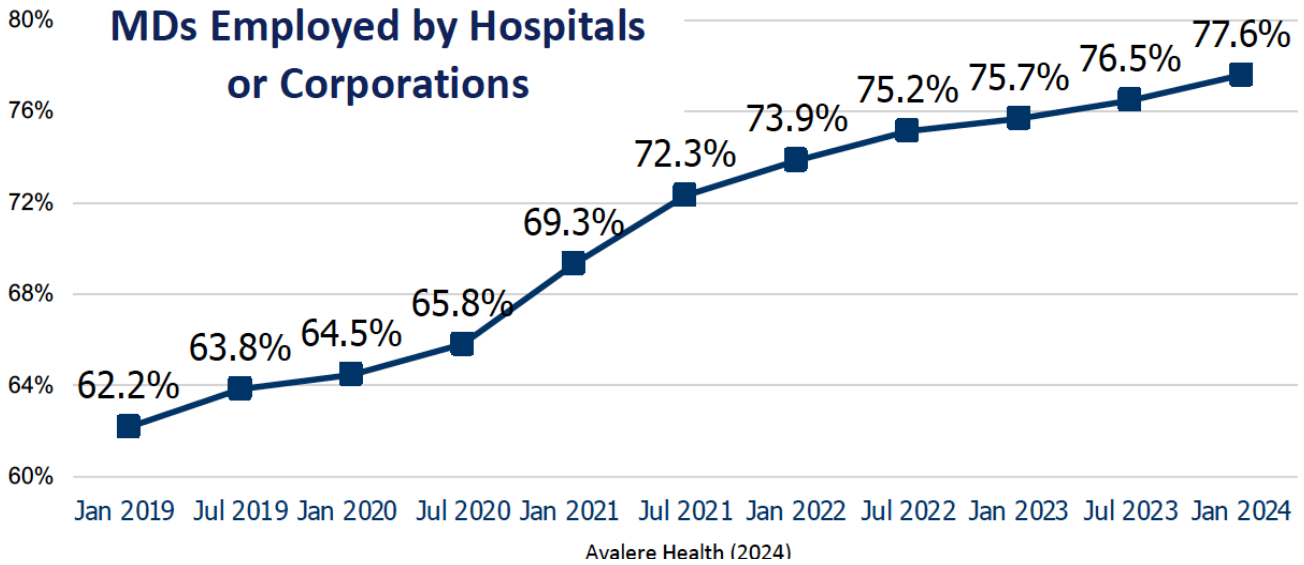
- Rhode Island has 7 hospital systems[1] and 16 hospitals, including:
  - 10 acute care hospitals
  - 3 psychiatric hospitals[2]
  - 2 rehabilitation hospitals
  - 1 long term acute care hospital[3]
- The hospital system with the largest volume by discharges in CY 2023 was Lifespan with 46%, followed by Care New England with 32%.

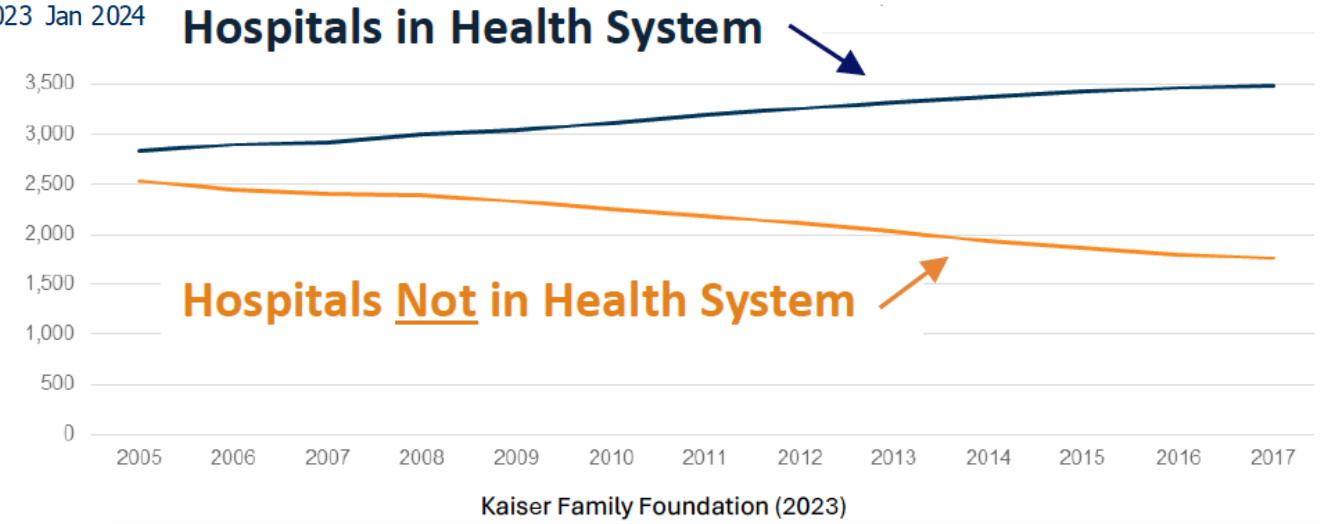


Source: RIDOH, Hospital Discharge Data, CY2023

1. Includes Encompass Health, owner of Rehabilitation Hospital of Johnston in addition to the six health systems represented in the RIDOH hospital discharge data and included in the graphic above.
2. Includes Rhode Island State Psychiatric Hospital
3. The state is in the process of retooling Eleanor Slater Hospital to a true long term acute care hospital (LTACH) with a modernized facility to treat medically complex patients.
4. Note, RI State-run facilities and the rehabilitation hospitals do not report to the RIDOH hospital discharge data set and therefore are not represented in the "Share of Inpatient Hospital Discharges by Health System and Hospital, CY2023"

A. National Trend Toward Consolidation & Financialization





Source: Excerpt from "Consolidation and Financialization in Health Care" presentation by Zirui Song, MD, PhD, Harvard Medical School, MassachusettsGeneral Hospital at NASHP on September 9, 2024

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A. National Trend Toward Consolidation & Financialization

Source: Excerpt from "Consolidation and Financialization in Health Care" presentation by Zirui Song, MD, PhD, Harvard Medical School, MassachusettsGeneral Hospital at NASHP on September 9, 2024

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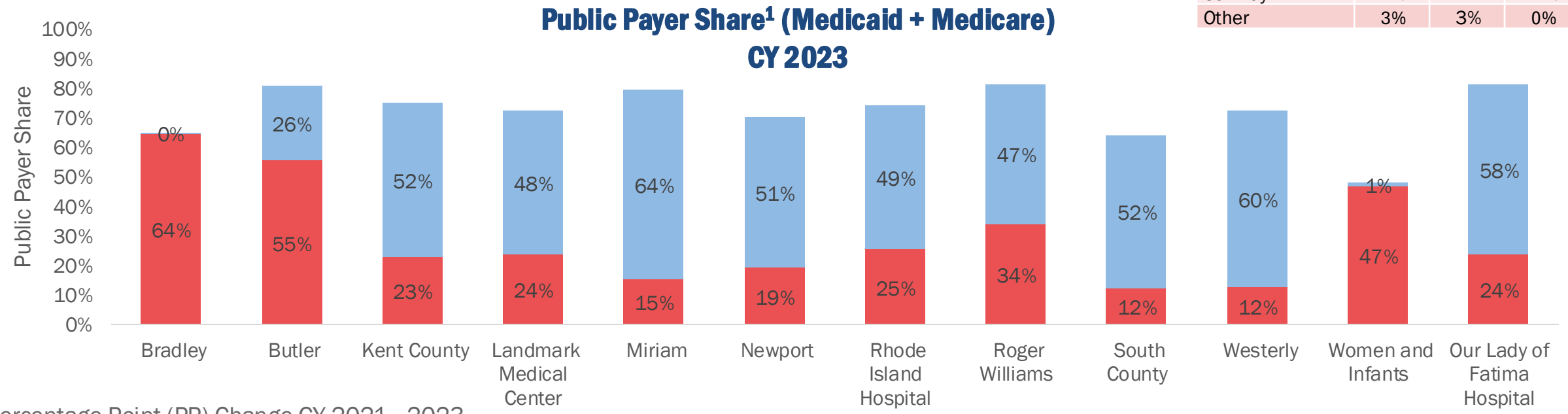
A. Overview - Increasing Public Payer Mix

As observed nationally, RI hospitals are seeing an increasing share of public payers, known to have lower reimbursement rates. Growth has been driven disproportionately by Medicare.

Statewide	2021	2023	PP ▲
Medicare	41%	43%	2%
Medicaid	27%	28%	1%
Public Payer Total	**68%**	**71%**	**3%**
Commercial	26%	25%	-1%
Self-Pay	4%	2%	-2%
Other	3%	3%	0%



Percentage Point (PP) Change CY 2021 - 2023

PP ▲	Bradley	Butler	Kent	Landmark	Miriam	Newport	RIH	Roger Williams	South County	Westerly	W&I	Fatima
Medicaid	1%	-3%	5%	-1%	0%	-3%	-1%	-2%	0%	-1%	4%	-1%
Medicare	0%	5%	8%	1%	1%	2%	1%	4%	4%	3%	0%	1%
Total Public	1%	3%	13%	-1%	1%	0%	1%	1%	4%	1%	4%	1%

Source: RIDOH, Hospital Discharge Data, CY2023
1. Public payer share based on share of inpatient discharges

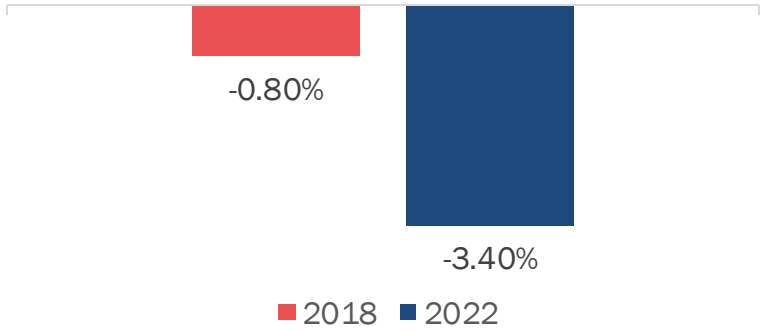
A. Overview - Financial Performance

In alignment with national trends, FY 2022 financial performance of RI's acute hospitals and health systems indicated financial stability concerns, with ongoing pandemic-related pressures impacting operations and market volatility affecting investments.

Acute care hospital operating margins remained positive, indicating financial pressures outside of hospital operations contributing to negative health system margins (e.g., physician practice performance among other factors)

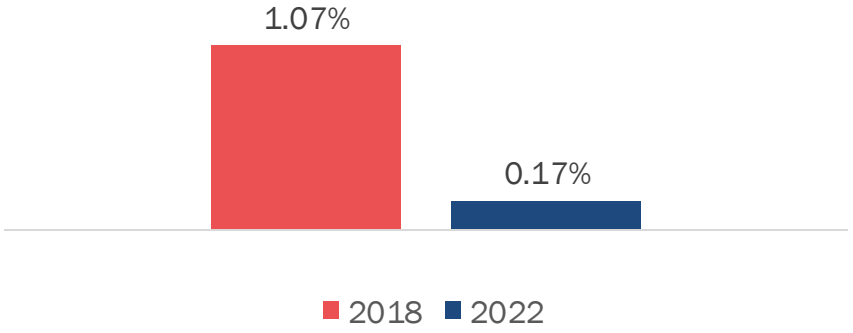
Statewide Health System Performance

Over the past five years, RI's health systems' operating margin experienced a significant downward shift, declining from a -0.8% operating loss in FY2018 to a -3.4% operating loss in FY 2022.



Statewide Acute Hospital Performance

RI experienced a statewide acute hospital operating margin drop from 1.07% in FY18 to 0.17% in FY 2022.



Source: Manatt Health RI Hospital and Health System Study, March 2024

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A. Overview – Health System Financial Performance

In FY 2022, all health systems across RI experienced negative operating margins, as reported in their audited financial statements.

Health System	Total Operating Revenue	Total Operating Expenses	Total Operating Margin	Total Operating Margin %
Care New England Health System	$1,230,400,000	$1,289,005,177	-$58,605,177	-4.8%
Lifespan	$2,827,881,000	$2,883,898,000	-$56,017,000	-2.0%
CharterCare	$350,315,000	$377,787,000	-$27,472,000	-7.8%
South County Health	$222,504,152	$228,981,110	-$6,476,958	-2.9%
Yale New Haven (Westerly ONLY)	$114,421,000	$128,051,000	-$13,630,000	-11.9%
Total RI Health Systems	**$4,745,563,669**	**$4,907,722,287**	**-$162,158,618**	**-3.4%**

Notes:
- The RI analysis does not include Prime Healthcare Services financial information in this Data Report.
- The RI statewide operating margin analysis includes Yale New Haven Health operating revenue and expense financials ONLY for The Westerly Hospital.
- The CNE Health System operating loss of $58 M is partly comprised of a $24 M goodwill impairment associated with Southeastern Healthcare System, Inc. and Affiliates for Memorial Hospital closure.

Source: Manatt Health RI Hospital and Health System Study, March 2024

Note, financials were not able to be confirmed and updated for FY 2023 in the given timeframe, but audited financials for RI Health Systems are largely publicly available.

B. Payment - Commercial Prices Relative to Medicare

- The RAND 5.0 hospital price transparency study found a **wide variation in relative prices across states in 2022**

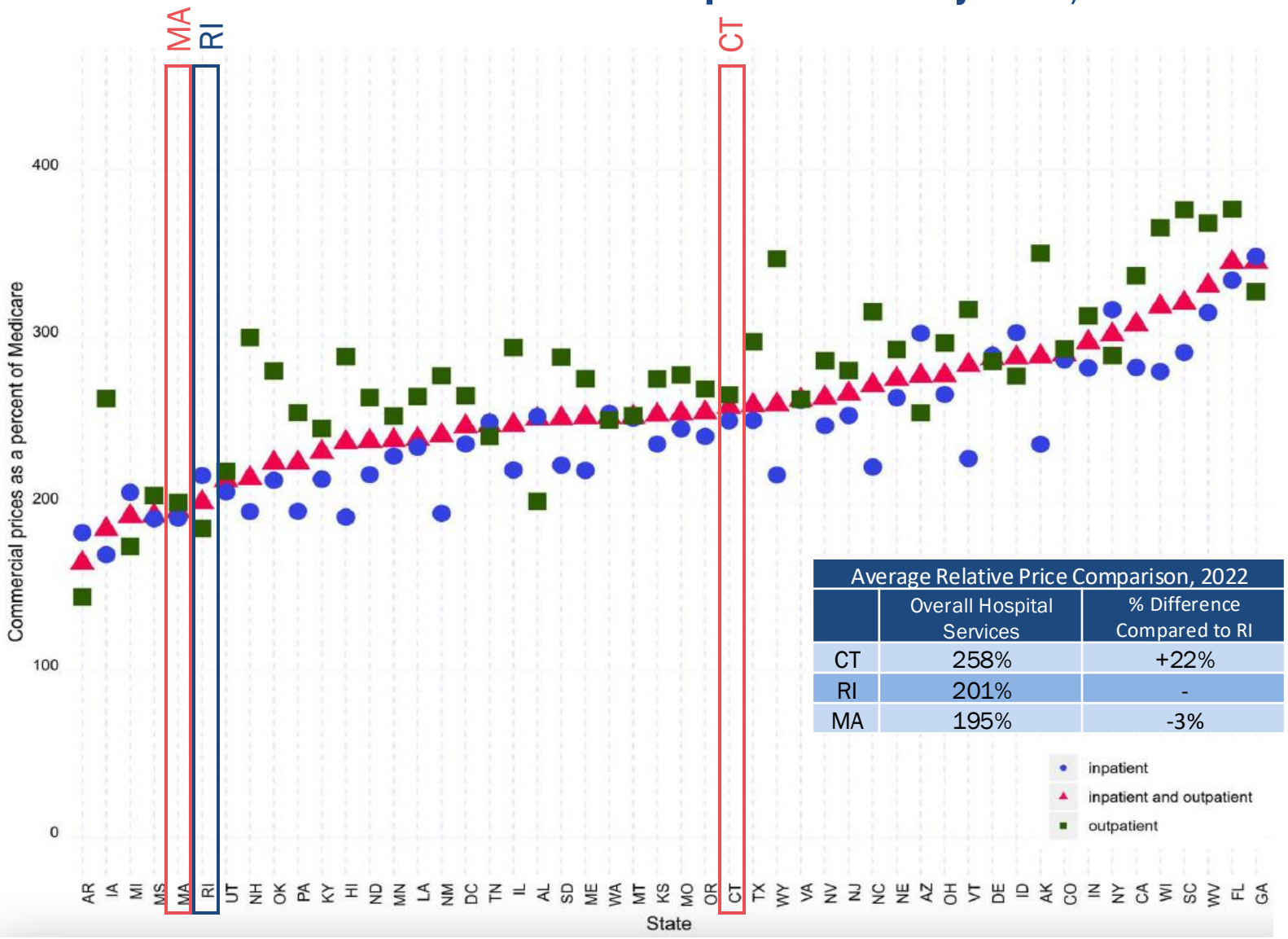
Relative Price: *The ratio of the actual private/commercial allowed amount divided by the Medicare allowed amount for the same services provided by the same hospital*

- In 2022, average overall relative price for hospital services nationwide was **254% of Medicare**, including inpatient and outpatient facilities, plus associated professional fees, across all data contributors.
- RI employer-sponsored health plans paid an average of **201% of Medicare** allowed costs for hospital services.
  - Comparatively, CT's average relative price was 22% higher, just above the nationwide average.
  - MA average relative price was 3% lower than RI.
- Relative prices for inpatient and outpatient facility services specifically, can be found below.

Average Relative Price Comparison, 2022		
	Inpatient Facility	Outpatient Facility
CT	256%	286%
RI	227%	189%
MA	194%	205%

Source: This slide updates findings reported in the Manatt Health Study (March 2024), using the latest 2022 data from RAND 5.0 and includes overall relative price, in addition to Inpatient and Outpatient Facility relative prices.

Overall Relative Prices for Hospital Services by State, 2022



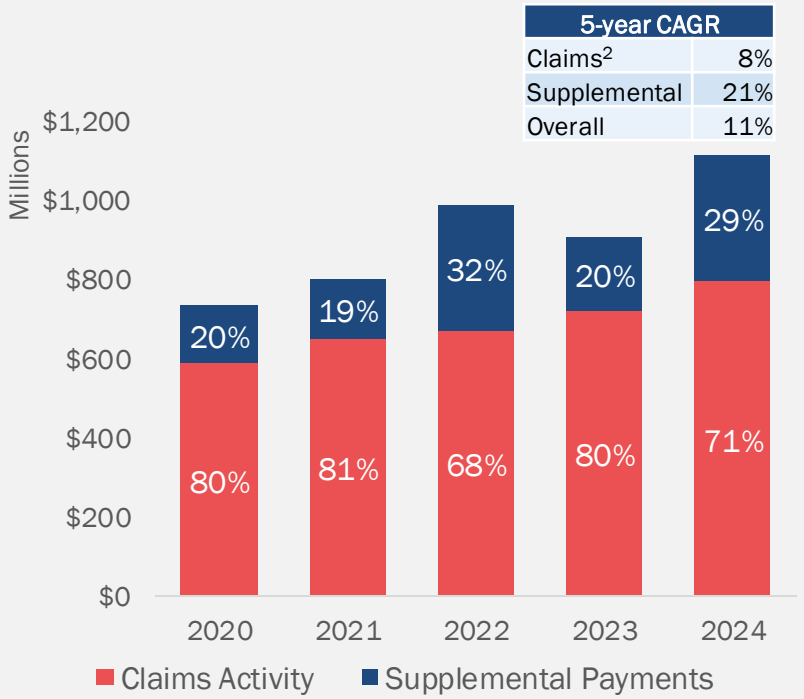
Average Relative Price Comparison, 2022		
	Overall Hospital Services	% Difference Compared to RI
CT	258%	+22%
RI	201%	-
MA	195%	-3%

B. Payment - Medicaid Hospital Expenditure

Supplemental payments have more than doubled over the past five years and make up a growing share of total Medicaid payments to hospitals, increasing from 20% to 29% from SFY 2020 to 24.

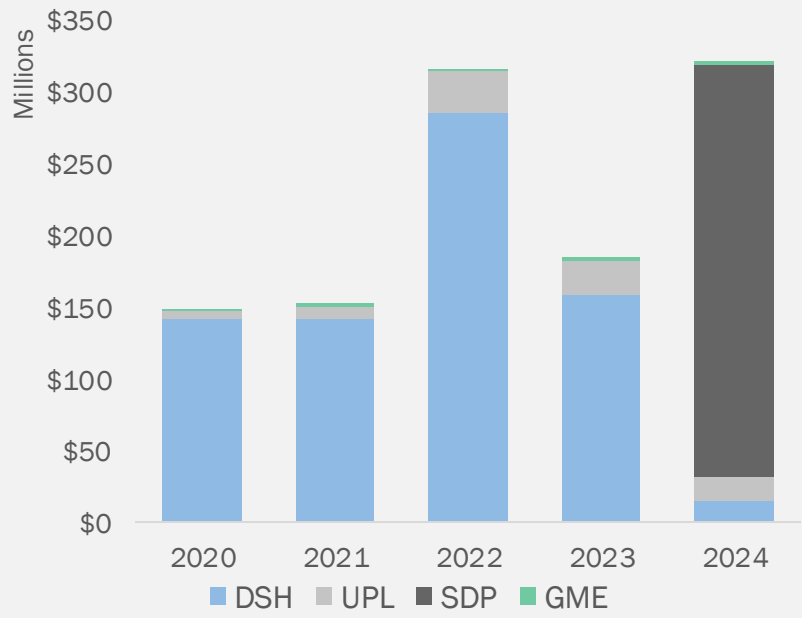
- RI uses a **combination of supplemental payment types,** including Disproportionate share hospital (DSH) payments, Upper Payment Limit (UPL) payments, Graduate Medical Education (GME) payments for teaching hospitals, and as of this year State Directed Payments (SDP).
- Historically, DSH payments constituted the majority of supplemental funding, accounting for 96% in SFY 2020. However, by 2024, SDPs largely replaced DSH, reducing its share to 5% of total supplemental payments.

RI Medicaid Hospital Expenditures
SFY 2020-24[1]



Source: RI Medicaid Expenditure Data Request, August 18, 2024

Supplemental Payments to RI Hospitals
by Type, SFY 2020-24



DSH % of Total Supplemental	2020	2021	2022	2023	2024
	96%	93%	90%	86%	5%

1. RI Medicaid hospital expenditures reported here exclude claims payments made to Eleanor Slater and out-of-state hospitals. Additionally, claims activity for SFY 2024 includes projected expenditures for Q3 and Q4.
2. Claims activity growth rate includes growth in rates and utilization.

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B. Payment - RI Supplemental Payment Types Detail

Payment Type	Payment Goals	Relationship to Other Payments	Additional Notes
Disproportionate Share Hospital (DSH) Payment	Statutorily required payments to hospitals that serve a high share of Medicaid and low-income patients.	Can be used offset low base payments, but they are the only type of Medicaid payment in statute that is explicitly intended to pay for unpaid costs of care for uninsured patients.	Changes to base and non-DSH supplemental payments can affect the amount of DSH funding a hospital is eligible to receive.
Upper Payment Limit (UPL) Payment	Lump-sum payments that are intended to fill in the difference between FFS base payments and the amount that Medicare would have paid for the same service. In the aggregate for each class of providers, FFS and UPL payments for services cannot exceed a reasonable estimate of what would have been paid according to Medicare payment principles.	Explicitly intended to supplement low FFS base payment rates. If states increase base payments rates to hospitals, the amount of UPL payments that a state can make is reduced.	Because UPL limits are established in the aggregate, UPL payments to individual hospitals can exceed the hospitals' costs as long as total payments for each class of providers are below the UPL. This policy is different than DSH, which cannot pay more than a hospital's uncompensated care costs.
State Directed Payments (SDP)	To ensure access to an adequate provider network and to increase the use of value-based payment (VBP) methods. There is currently no upper limit on the amount of payments states can make through directed payments. However, CMS recently proposed to cap directed payments to hospitals at the average commercial rate, which is substantially higher than the Medicare payment rate limit used for UPL payments.	Similar to UPL payments, directed payments offset Medicaid shortfall and thus reduce the total amount of DSH payments an individual hospital can receive. Directed payments to hospital systems for non-hospital services (e.g., professional services provided at an academic medical center) do not count toward the DSH hospital-specific limit.	CMS identifies three different types SDPs: 1) Minimum or maximum fee schedule: sets parameters for base rates that MCOs pay for specified services; 2) Uniform rate increase: requires MCOs to pay a uniform dollar or percentage increase above negotiated base rates – this arrangement is most similar to supplemental payments in FFS; 3) VBP: requires MCOs to implement VBP models and includes arrangements that require MCOs to participate in multi-payer or Medicaid-specific delivery system reforms.
Graduate Medical Education (GME) Payment	Help support teaching hospitals costs- higher costs can reflect both the direct costs of training and indirect costs associated with a more severe case mix. Some states make GME payments as a supplemental payment, while other states account for GME costs in the calculation of base payments to teaching hospitals.	States can make GME supplemental payments in both FFS and managed care delivery systems. GME payments are considered Medicaid payments for the purposes of calculating Medicaid shortfall for DSH and UPL purposes.	

Source: Medicaid Base and Supplemental Payments to Hospitals, MACPAC Issue Brief (2024)

C. Investment - New CMS Rule re: Provider Taxes

- On September 9th CMS released **new guidance to states regarding healthcare related tax programs with redistribution arrangements.**
  - Redistribution arrangements: In some impermissible arrangements, providers have pre-arranged agreements to redistribute Medicaid payments to repay all or a portion of the health care-related tax.
- **FOR NEW ARRANGEMENTS:** Health care-related taxes that do not meet federal requirements or new provider payment redistribution arrangements **may result in CMS disapproval** of state Medicaid payment proposals and/or disallowance of Federal Financial Participation (FFP).
- **FOR EXISTING ARRANGEMENTS:** On April 22, 2024, CMS issued an informational bulletin (CIB) indicating that it will exercise enforcement discretion until January 1, 2028, with respect to health care-related tax programs with hold harmless arrangements that exist as of the date of the CIB.
- **Before January 1, 2028:**
  - CMS will identify and track all **existing** provider redistribution arrangements **as of the date of the CIB (April 22, 2024)**, when possible, through reviews of SDPs, state plan amendments, and other means.
  - CMS will assist states, where necessary, to identify and **transition to allowable sources** of non-Federal share while mitigating any program disruption to the greatest extent possible.

For additional information on allowable/unallowable arrangements and adjustments to provider taxes for states with new or existing arrangements see "Overview of CMS Enforcement Discretion Regarding Existing Health Care-Related Tax Programs with Impermissible Redistributions" (Sept 9, 2024)

C. Investment - Hospital Global Budgeting

Hospital global budgets give hospitals incentives to manage the provision of services and improve operating efficiency.

Hospital global budgets aim to[1]:

- Remove fee-for-service incentives that induce hospitals to provide unnecessary and low-value care
- Allow states to effectively constrain hospital expenditure growth for all payers
- Encourage hospital investments in population health initiatives and resources that address social determinants of health and social supports
- Guarantee a predictable revenue flow for the hospital and flexibility to allocate resources efficiently under the budget constraint
- Support other budget-based efforts at cost reduction and health improvement, such as ACOs

Since Hospital global budgets are a key component of the **AHEAD model,** there may be an opportunity for alignment

Payment Models That Cover Larger Service Bundles Enable Hospitals to Better Manage Their Costs

	Categories of cost					
Basis of payment	**Unit costs**	**Ancillaries per day**	**Length of stay**	**Defined pre- and posthospitalization services**	**Hospital readmission rates**	**Total services per resident (PMPM)**
1. Discounted (itemized) charges	✔					
2. Per-diem payments	✔	✔				
3. Per-case payments (DRGs)	✔	✔	✔			
4. Episodes of care	✔	✔	✔	✔		
5. Global budgets	✔	✔	✔	✔	✔	
6. Capitation (PMPM)	✔	✔	✔	✔	✔	✔

Note: DRGs = diagnosis-related groups.
Data: Author's analysis.

Source: Robert Murray, *Hospital Global Budgets: A Promising State Tool for Controlling Health Care Spending* (Commonwealth Fund, Mar. 2022). https://doi.org/10.26099/98xk-am95

1. Murray, R. (2022, March 22). *Hospital Global Budgets: A Promising State Tool for Controlling Health Care Spending.* The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2022/mar/hospital-global-budgets-state-tool-controlling-spending

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C. Investment - 1115 Waiver, NY VAPAP Example

New York has used the DSHP authority under their 1115 Waivers for FFP to provide support to facilities in financial distress under the Hospital Vital Access (VAP or VAPAP) Program

The VAPAP program provides temporary (up to 3 years) of **state-only support for facilities in severe financial distress to enable these facilities to maintain operations and provision of vital services** while they implement longer-term solutions to achieve sustainable health care service delivery. Funding is provided for operational costs associated with transformation initiatives that **address financial viability, community service needs, quality of care, and health equity.**

VAPAP Financing: DSHP Eligible Expenditures, Population adjusted to RI - $133 Million

- VAP (or VAPAP) is the primary funding vehicle the DOH will use to support multiyear transformation initiatives
- VAP grants approved by CMS receive federal financial participation
- NY Public Law, Section 2826, Temporary adjustment to reimbursement rates: NY is using this authority (section g specifically) for payments to hospitals under the current VAPAP or VAP program

CMS Guidelines for DSPH Authority:

- The state must use the “freed up” state funding on a new demonstration initiative that CMS has determined is likely to assist in promoting the objectives of Medicaid, such as improving access to high-quality covered services.
- New York will be required to contribute state funds other than those freed up by the federal investment in DSHP for expenditures under the DSHP-supported demonstration initiative.

C. Investment - 1115 Waiver, NY VAPAP Example

New York has used the DSHP authority under their 1115 Waivers for FFP to provide support to facilities in financial distress

Program	DSHP-Eligible Expenditures
Area Health Education Centers (AHEC)	$8,800,000
Doctors Across New York (DANY) Diversity in Medicine	$6,220,000
DANY Physician Loan Repayment and Practice Support	$54,420,000
Health Care Workforce Bonus (HWB) Program	$766,998,088
Health Workforce Retraining (Increase Training Capacity)	$28,186,550
Nurses Across New York (NANY)	$12,000,000
Vital Access Providers Assurance Program (VAPAP)	**$2,404,793,968**
Alzheimer's Caregiver Support	$105,468,000
Cancer Services	$89,300,000
CSEA Buy-in	$13,200,000
Elderly Pharmaceutical Insurance Coverage (EPIC)	$250,068,000
End of AIDS	$60,000,000
Expanded In-home Services for the Elderly (EISEP)	$20,000,000
MLTC Ombudsman	$20,000,000
Newborn Screening	$38,941,504
NY Connects	$95,600,000
Obesity - Diabetes Prevention Programs	$23,880,000
Supportive Housing Initiative	$163,212,000
Tobacco Control	$162,576,000
Total Allowable DSHP-Eligible Expenditures	**$4,323,664,110**
Total DSHP Cap.	**$3,981,442,500**

NYS 1115 Waiver – DSHP Authority
STCs - Attachment N - Approved List of DSHPs
Specific state programs for which FFP can be claimed.

The VAPAP program provides state-only support for facilities in severe financial distress to enable these facilities to maintain operations and provision of vital services while they implement longer-term solutions to achieve sustainable health care service delivery.

- *Population adjusted to RI - $133 Million*

Population adjusted to RI: $220 Million

D. Transparency – State Examples

Several states require hospitals to disclose standard and/or custom financials to enhance transparency and cost monitoring

	Types of Hospitals with Required Reporting	State Disclosure Requirements for Standard Reports
Arizona	Acute Hospitals, Non-Acute Hospitals, Psychiatric Hospitals, Nursing Homes, Hospice Facilities,	Audited Financial Statement, Audited Financial Statement Consolidating Schedule, Medicare Cost Report, Chargemaster
California	Acute Hospitals, Non-Acute Hospitals, Psychiatric Hospitals, Nursing Homes, Hospice Facilities, Intermediate Care Facilities	Chargemaster
Colorado	Acute Hospitals	Audited Financial Statement, Audited Financial Statement Consolidating Schedule, Medicare Cost Report, IRS Form 990
Florida	Acute Hospitals, Non-Acute Hospitals, Psychiatric Hospitals, Nursing Homes, Hospice Facilities, Intermediate Care Facilities	Audited Financial Statement, Audited Financial Statement Consolidating Schedule
Georgia	Acute Hospitals (Non-Profit only)	Audited Financial Statement, Audited Financial Statement Consolidating Schedule, IRS Form 990
Indiana	Acute Hospitals	Audited Financial Statement, Medicare Cost Report
Maine	Acute Hospitals	Audited Financial Statement, Audited Financial Statement Consolidating Schedule, Medicare Cost Report, IRS Form 990
Maryland	Acute Hospitals, Non-Acute Hospitals, Psychiatric Hospitals	Audited Financial Statement, Audited Financial Statement Consolidating Schedule
Massachusetts	Acute Hospitals, Non-Acute Hospitals	Audited Financial Statement, Audited Financial Statement Consolidating Schedule, Medicare Cost Report, IRS Form 990, Chargemaster
Missouri	Acute Hospitals	*Missouri does not require any of these “standard” reports, but instead requires other financial data determined by statute and agency rulemaking
New Jersey	Acute Hospitals, Non-Acute Hospitals, Nursing Homes	Audited Financial Statement
Washington	Acute Hospitals, Psychiatric Hospitals	IRS Form 990

Source: National Academy for State Health Policy (NASHP). Snapshot of 12 States’ Hospital Financial Transparency Laws. (2020). https://nashp.org/snapshot-of-12-states-hospital-financial-transparency-laws/

D. Transparency - Best Practice Approaches

Massachusetts and Colorado offer helpful models for fiscal transparency & oversight

Key Aspect	Massachusetts	Colorado
Oversight Entity	Center for Health Information and Analysis (CHIA)	Colorado Department of Health Care Policy & Financing (HCPF)
Statutory Scope and Purpose	957 CMR 9.00: Governs the financial reporting requirements for acute and non-acute hospitals, including their Parent Organization and Physician Organization(s) for the submissions of hospital cost reports, charge books, and quarterly and annual financial data filings.	House Bill (HB) 19-1001 Hospital Transparency Measures to Analyze Efficacy requires HCPF to develop and publish a report on uncompensated costs of care and the different expenditures made by hospitals in the state. HB23-1226 Hospital Transparency and Reporting Requirements expands upon HB19-1001 to create more timely submissions of data; **to create additional reporting requirements on transfers of cash, profits, and reserves**; to report more executive compensation; and to report mergers and acquisitions of hospitals and physicians.
Process	**Hospitals must submit to CHIA:** annual and quarterly financial reports.	**Hospitals must submit to HCPF**: historic (if available) and recent audited financial statements, Medicare cost reports, historic and recent financial and utilization metrics, acquisition transactions, and affiliation transactions.
Financial reporting non-compliance penalties	May be subject to a penalty of up to $1,000 per week for each week that they fail to provide the required health care data and information, up to an annual maximum of $50,000.	The **state department shall issue a corrective action plan.** If a hospital continues to not comply, **the state department may create a mandatory pay-for-reporting compliance measure.** If a hospital's noncompliance is knowing or willful or there is a repeated pattern of noncompliance, **the state department shall consider the size of the hospital and the seriousness of the violation in setting a fine amount.**
How is the state using data to monitor hospitals?	**Reporting, Cost-Monitoring, Financial Transparency** • May require any entity referred to it by CHIA to complete a Performance Improvement Plan (PIP) if it identifies significant concerns about the Entity's costs and determines that a PIP could result in meaningful, cost-saving reforms	**Reporting and Financial Transparency**

1. Colorado Department of Health Care Policy and Financing (HCPF). Hospital Financial Transparency. (2024). https://hcpf.colorado.gov/hospital-financial-transparency
2. Massachusetts Health Policy Commission (HPC). Provider Financial Data Collection and Examples of Use. (2024).

D. Transparency – RI Regulatory Environment

There appears to be a strong starting point for the proposed enhanced fiscal monitoring and oversight of hospitals – with some enhancements to capture the system level, that would need to be coordinated across agencies and more adequately resourced

Department	Area of Oversight	Authority and Responsibilities
DOH	Quality	• Collects quality data under licensure authority - DOH also has broad authority to enact regulations to promote safe and adequate treatment of patients that are in the interest of the public health, safety and welfare.
	Financials	• Requires annual submission of audited financial statements, financial position statements, and healthcare service costs. • Currently does not take an active role in reviewing financial information • Recently engaged a third party to review hospital financial information
	Charity Care, Uncompensated Care, Community Benefits	• Oversees charity care, uncompensated care and community benefit requirements but performs little oversight of compliance other than confirming the required reports were submitted to ensure accessibility for under- and uninsured
	Reporting Regulation & Data Distribution	• Imposes reporting obligations and participates in making data trends public (efforts have been limited due to funding)
	Inequities and Disparities	• The Commission for Health Advocacy & Equity advises on ways to address inequities and disparities in care. The Commission prepares a biennial disparities impact and evaluation report, and may draft and recommend proposed legislation, regulations and policies designed to address health disparities.
	Health Care Facility Licensing	• The Health Services Council (4 representatives from OHIC, EOHHS, health insurance business, Executive Office of Commerce) must approve any change in owner, operator or lessee of any licensed healthcare facility.
	Certificates of Need	• The Health Services Council together with the DOH reviews all applications for Certificates of Need (CON), including new applicants to provide licensed services, capital expenditures if they result in a change in services or bed capacity, and new healthcare equipment that exceeds $2,250,000.
EOHHS	Medicaid Payment Reform	• Broad authority to implement Medicaid payment reform initiatives (subject to CMS approval) • No independent authority to review hospital or provider finances outside of Accountable Entities (AE) certification
	Accountable Entities (AE)	• Oversees AEs with cost, quality, and performance benchmarks • Conducts annual recertification of AEs
OAG	Hospital Conversions	• Evaluates financial health and access to care during hospital conversions • No general oversight authority over health system costs or providers' financial health
OHIC	Quality	• Sets and oversees requirements driving affordable care
	Cost Containment	• Focuses on rate caps for hospitals • Ensures insurers meet certain spend targets
Joint	Hospital Conversions	• OAG focuses on financial impact and DOH focuses on accessibility and affordability – the OAG and DOH review concurrently to come to a decision regarding hospital conversions
	APCD	• DOH, OHIC, EOHHS, HSRI, and RI Benefits Exchange work together to collect claims data from a variety of payer sources • APCD law and regulations fall under DOH

Source: Legal and Regulatory Framework, February 21, 2023 | Manatt, Phelps & Phillips, LLP

D. Transparency – RI Enforcement Mechanisms

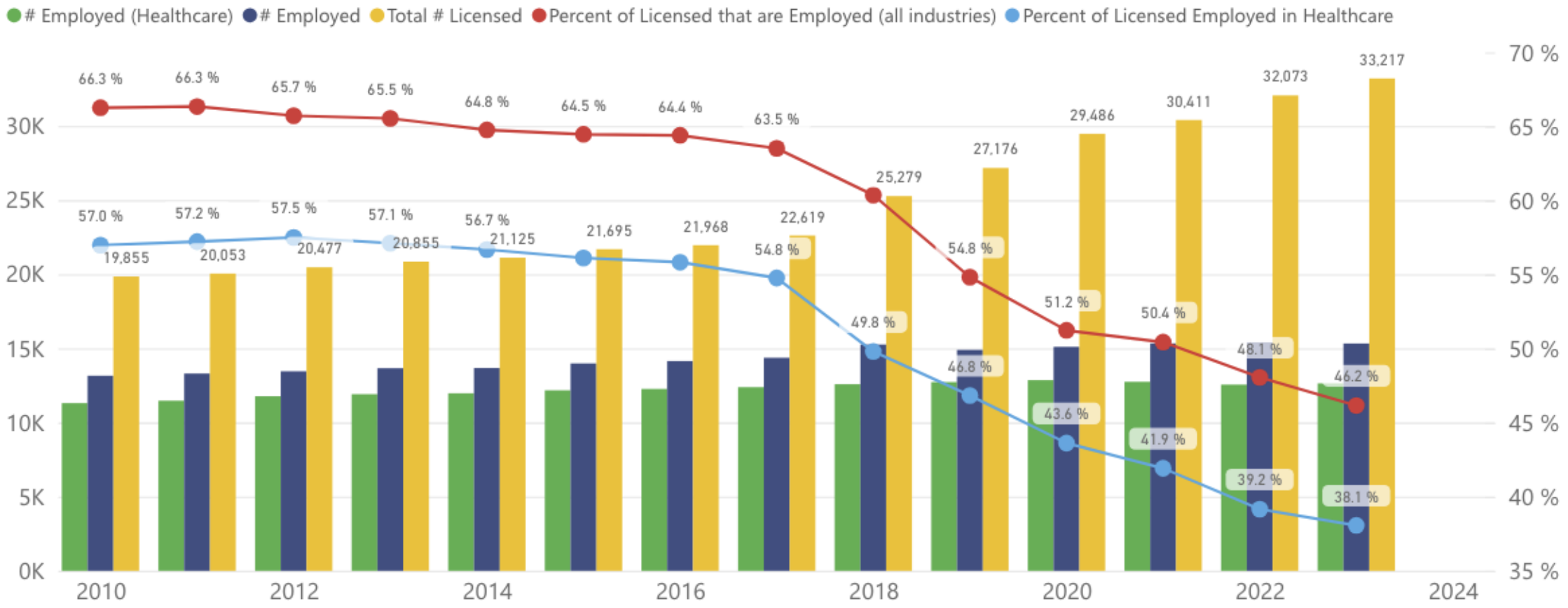
There appear to be substantive enforcement mechanisms across RI agencies that could be leveraged for this process – if adequately resourced and coordinated across agencies

Department	Enforcement
DOH	• General enforcement limited to licensure actions, compliance orders, prohibiting admissions or requiring patient transfers, other corrective actions, and minor fines • DOH oversees charity care through holding hearings and issuing penalties as needed • DOH is currently evaluating its capacity to engage in meaningful oversight over compliance of these requirements as part of its strategic initiatives
EOHHS	• Enforcement limited to provider enrollment, Medicaid overpayment recovery, and certifying reform initiative participants
OAG	• OAG enforces hospital conversions in partnership with the DOH through approval, approval with conditions, or disapproval of the hospital's application
OHIC	• The Commissioner can take an insurer's treatment of consumers and providers into account when OHIC approves or denies any request or application, any requested rate, and any forms, trend factors or other filings.
	• OHIC enforces its oversight through issuances of orders, decisions and rulings, or initiating proceedings, hearings, examinations or inquiries.

The above table summarizes findings from a Manatt/RI Foundation report (Feb 2023) on existing legal and regulatory frameworks in Rhode Island
Source: Legal and Regulatory Framework, February 21, 2023 | Manatt, Phelps & Phillips, LLP

E. Other - Workforce: Registered Nurses (RNs) in RI

While the total number of licensed RNs in RI has been steadily increasing over the last 8 years, the percentage of licensed RNs that are employed in the healthcare industry has dropped from 56% to 38% over the same period.



Note, partial data for CY2024 is not reported but is available on the RI EOHHS Health Workforce Data Dashboard through July 15, 2024
https://eohhs.ri.gov/health-workforce-dashboard

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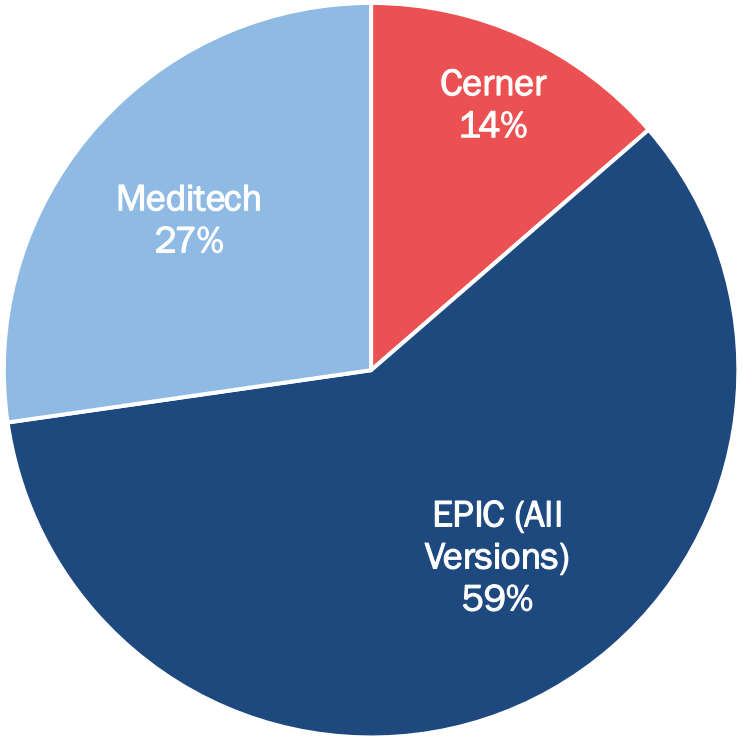
E. Other –Electronic Medical Record (EMR) Systems in RI Hospitals

RI Hospitals are utilizing Epic, Cerner, and Meditech EMR Systems, which are widely used in hospitals across the US.

- EMR Systems have been seen to both improve patient care and increase operational efficiency[1]:
  - EMR systems enhance accuracy and accessibility of patient information and support clinical decision-making and continuity of care.
  - EMR systems generate meaningful statistics used in health care service planning and management
- EMR systems can often be time consuming and burdensome to nurses and providers[2]:
  - Nurses and doctors on average spend 50% of their workday with EMRs instead of with patients and some emergency department physicians cited spending most of their time using EMRs.
  - Health care providers often associate burnout with EMR use

Distribution of EMR Systems Adopted in RI Hospitals (2024)[3,4]



- Bradley – EPIC (LifeChart)
- Butler – Cerner & EPIC
- Fatima – Meditech
- Kent – Cerner
- Landmark – EPIC
- Miriam – EPIC (LifeChart)
- Newport – EPIC (LifeChart)
- RIH – EPIC (LifeChart)
- RWMC – Meditech
- South County – Meditech
- Westerly – EPIC (YNNH)

1. Zhang X, Zhang X. Recent perspectives of electronic medical record systems. Exp Ther Med. 2016;11:2083–5.
2. National Academies of Sciences, Engineering, and Medicine. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC: The National Academies Press; 2019
3. EMR systems for rehabilitation hospitals were unable to be confirmed for inclusion, and state-owned hospitals are not currently utilizing EMR systems but are in the procurement process.
4. Each hospital is weighted equally regardless of size; for hospitals using different EMRs for inpatient and outpatient services, the hospital was divided equally between the two systems.

Note: This material provides additional details on problem statements and solutions as reference. It will not be reviewed during the meeting

Appendix #2

Detailed Problem Statements & Preliminary Solutions

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Appendix #2 Materials

This separate word document details all draft problem statements and solutions; largely reflects working group interview learnings + local and national landscape reviews.

A. **Problem Statements:** Detailed problem statements and interviewee priorities

B. **Strategies/Opportunities:** Preliminary list of strategies to consider, aligned with problem areas

See separate attachment/word document:
"Detailed Problem Statements & Preliminary Solutions"

Note: Slides in this section are provided to all workgroups for context setting. There will not be time dedicated to reviewing this content during Meeting #1

Appendix #3

Broader Cabinet Reference Materials

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Appendix #3 Materials

Broader Cabinet Reference Materials, provided to each of the working groups as context

A. Purpose & Goals of RI Health Care System Planning (HCSP) Initiative

B. Workgroup Charge & Meeting Schedule

C. Rhode Island HCSP Initiative Timeline

D. Final HCSP Report Structure and Content (December 2024 Deliverable)

A. Purpose & Goals of RI Health Care System Planning Initiative

Overarching Goal: High-quality, affordable, equitable, accessible, culturally and linguistically appropriate health care system

The HCSP will be developed through a comprehensive planning process that:

- Applies quality data for actionable health care policy, oversight, and accountability
- Engages a broad and inclusive group of stakeholders, including residents/health care consumers
- Coordinates with other health and human service systems to ensure continuity of care, supportive service delivery and basic needs
- Aligns current and future needs
- Is overseen by the Health Care System Planning Cabinet (HCSP Cabinet) with the support and cooperation of all departments, offices, boards and agencies

A. Purpose & Goals - Health Care System Planning Goals

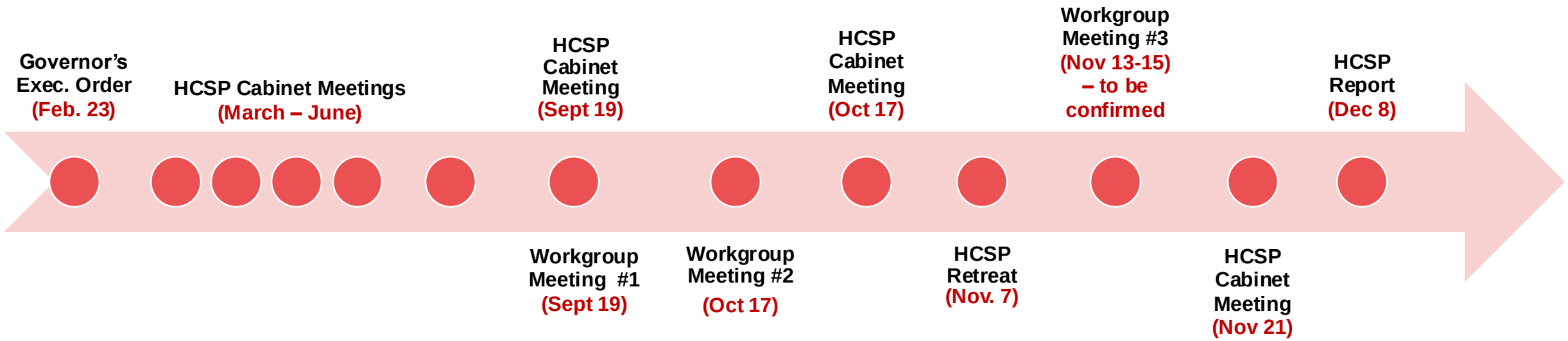
- Ensure **solvency** of the health care system
- Foster an **integrated delivery system that coordinates care** across the health care continuum focused on population health, care transitions, and patient-centered care
- Ensure **access to affordable, quality, easy to navigate, and comprehensive care**
- Ensure **health equity and reduce disparities** in access and outcomes
- Incentivize **investments in system transformation** to promote innovation
- Strengthen **preventive, and primary physical & behavioral health services** to maintain appropriate utilization & promote efficiencies
- Invest in efforts to address the **social factors that impact health**
- Establish state infrastructure to **oversee health system performance**, improvement, and equity, as well as promote transparency

B. Workgroup Charge and Meeting Schedule

- **Workgroup Charge:**
  - Provide critical input regarding the Hospital Sector's strengths, services gaps, challenges, and strategic opportunities to enhance access, quality, equity, and performance

- **Meeting Schedule:**
  - Workgroup Meeting #1: Hospital Sector Challenges & Draft Solutions (Today)
    - Objective: To confirm challenges impacting the RI hospital sector and discuss potential strategies and solutions
  - Workgroup Meeting #2: Discussion and Prioritization of Strategic Opportunities (Oct 17th 2:00-3:30)
    - Objective: Review, discuss, and prioritize emerging strategic opportunities to leverage identified strengths and address challenges.

C. Timeline - Rhode Island HCSP Initiative Timeline



D. Final HCSP Report Structure and Content

Purpose and Content of December Report

The Rhode Island Health Care System Plan Report will:

- Clarify the State's health system strengthening framework
- Provide a preliminary assessment of the current capacity, strength, and future needs of the State's healthcare system by sector and a series of cross-cutting structures
- Identify and explore enhancements to the state structures, policies, and other levers that will facilitate implementation and support health system strengthening efforts
- Identify and prioritize the assessment's key findings and an associated set of emerging recommendations or strategic opportunities
- Develop an action-oriented Health Care System Plan Report that details the purpose of the plan, the process applied to develop it, key findings, and short-term and long-term action steps to address the issues identified