



## **RI Health Care System Planning - Hospitals Workgroup**

### **Meeting #2: Discussion and Prioritization of Strategic Opportunities**

***October 17, 2024***

Note: These materials should be considered preliminary working documents, in support of Meeting #2. Problem statements and solutions identified here have not yet been confirmed by the working group as a whole.

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# Table of Contents/ Materials for Meeting #2

Materials	Pages	Topics Addressed	Description
<b>Meeting #2 Discussion Materials</b>  <b>HIGHEST PRIORITY FOR YOUR REVIEW</b>	Pages 5-29 of this document	I. Background & Context II. Review Refined Problem Statements & Priorities III. Deep Dive on Priority Strategies ( <b>primary focus</b> ) IV. Next Steps	Meeting #2 Discussion Materials are designed to drive the group towards: <ol style="list-style-type: none"> <li>Finalizing Principles (slide 11)</li> <li>Finalizing Problem Statements (slides 16-17)</li> <li>Establishing Priority Strategies (<b>slides 20-27</b>)</li> </ol>
<b>Appendix 1</b> RI Hospital Sector Starting Point & National Landscape Review	Pages 31-62 of this document	Compilation of existing data on the national and local hospital landscape. Please note, the following materials have been added based workgroup participant requests. <ol style="list-style-type: none"> <li>Overview of National Landscape (Slide 33)</li> <li>RI Outmigration of Services (Slide 36)</li> <li>2023 Operating Margins by Payor (Slide 39)</li> <li>Preliminary HCSP Workforce Recommendations (Slides 60-61)</li> <li>National Trends of Private Equity (Slides 53-56)</li> </ol> Note references to recent <a href="#">RI Foundation Reports</a> .	Appendix materials will be referenced as needed <b>but will not be reviewed during the meeting.</b> <ul style="list-style-type: none"> <li>These materials provide detailed information for the committees' consideration.</li> <li>Working group members are encouraged to review these materials in advance of the meeting to ensure we have a common starting point.</li> </ul>
<b>Appendix 2</b> Detailed Problem Statements & Preliminary Solutions	Pages 63-68 + Separate Word Document	<ul style="list-style-type: none"> <li>Details all draft problem statements and solutions.</li> <li>Largely reflects input collected during one-on-one interviews with working group members in addition to learnings from local and national landscape reviews.</li> </ul>	
<b>Appendix 3 (Newly Added)</b> Comments for Workgroup Consideration	Pages 69-73	<ul style="list-style-type: none"> <li>Comments from workgroup participants, collected from the Priority Solutions Survey, organized by topic area</li> </ul>	
<b>Appendix 4</b> Broader Cabinet Reference Materials	Pages 74-79 of this document	<ul style="list-style-type: none"> <li>Purpose, Goals, Key Areas of Inquiry, and Expectations of the Rhode Island Health Care System Planning (HCSP) Initiative</li> <li>Role of the Work Group, Key Deliverables/Timeline, and Content of the December 2024 RI HCSP Report</li> </ul>	

# Co-Chair Introductions

# Reminder: Meeting Norms

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- 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 **all participants** to contribute
- Mute your microphone when not speaking

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

# Agenda – Meeting #2

Topic	(Time 90 mins)
<b>I. Background &amp; Context</b> <ul style="list-style-type: none"><li>• Workgroup Charge and Meeting Schedule</li><li>• Workgroup Participants</li><li>• Goals for Today</li><li>• Refined Workgroup Principles</li><li>• Discuss questions on new materials included in RI Hospital Sector Starting Point &amp; National Landscape Review (Appendix 1)</li></ul>	15 Minutes
<b>II. Review Refined Problem Statements &amp; Priorities*</b>	15 Minutes
<b>III. Deep Dive on Priority Strategies*</b>	50 Minutes
<b>IV. Next Steps</b> <ul style="list-style-type: none"><li>• Meeting #3</li><li>• Plan for Retreat</li></ul>	10 Minutes

\* See Meeting #2 Appendix 2. Detailed Problem Statements & Preliminary Solutions Version 3 (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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# 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 (Sep 19th 11:30-2:00)**
    - Accomplished: Confirmed challenges impacting the RI hospital sector and discussed potential strategies and solutions
  - **Workgroup Meeting #2: Discussion and Prioritization of Strategic Opportunities (Today)**
    - Objective: Review, discuss, and prioritize emerging strategic opportunities to leverage identified strengths and address challenges.
  - **Workgroup Meeting #3: To be scheduled, tentatively Nov 4<sup>th</sup> - 6<sup>th</sup>**
    - Objective: Confirm priority strategies and recommendations to include in final report
  - **HCSP Cross-Sector Retreat: Share Findings & Identify Areas for Collaboration (Nov 7th 8:00-3:30)**

# Working Group Participants

## Hospital Sector Working Group Facilitators, Staff, and Members

Facilitators	Workgroup Members	
<p><b>Chair:</b> Secretary Rick Charest (EOHHS)  <b>Community co-facilitator:</b> John Fernandez (Lifespan)</p> <p>Assistant Secretary Ana Novais (EOHHS)            Commissioner Cory King (OHIC)            Director Matt Weldon (DLT)</p>	<b>Hospital Leadership</b>	<b>Subject Matter Experts (SMEs)</b>
<b>Staff</b>	<ul style="list-style-type: none"> <li>• Mike Wagner (CNE)</li> <li>• Mike Souza (Landmark)</li> <li>• Mary Marren (CNE/Butler)</li> <li>• Aaron Robinson (South County Health)</li> <li>• Lou Giancola (South County, retired)</li> <li>• Ara Milette (Lifespan)</li> <li>• Cedric Priebe (HIT Steering Committee/ Lifespan)</li> <li>• Lisa Tomasso (HARI)</li> </ul>	<ul style="list-style-type: none"> <li>• Martha Wofford (BCBS of RI)</li> <li>• Julia Harvey for Attorney General Neronha (AGO)</li> <li>• Sam Salganik (RIPIN)</li> <li>• Linda Katz (Healthcare Coalition, retired)</li> <li>• Marie Ganim (OHIC Commissioner, retired)</li> <li>• Alyssa Alvarado (DLT)</li> <li>• Al Charbonneau (RIBGH)</li> <li>• Jane Hayward (RIF, retired)</li> <li>• Pat Crowley (AFL-CIO)</li> <li>• Lynn Blais (UNAP)</li> <li>• Susan Jacobsen (Thundermist Health Center, HEZ)</li> <li>• Rosemary Costigan (CCRI)</li> <li>• Diana Franchitto (Hope Health)</li> <li>• Stacy Paterno (RIMS)</li> <li>• Mukesh Jain (Brown Medical School)</li> <li>• Gerry Goulet (Health Policy Analytics LLC)</li> <li>• Michelle Sears (NHPRI)</li> <li>• Anusha Venkataraman (ONE Central Providence, HEZ)</li> <li>• Mark Jacobs (MD, retired)</li> </ul>

# Goals for Today

By the end of today's meeting, we will have finalized Hospital Sector problem statements and confirmed a refined set of priority strategies

## Finalize Working Group Principles

- Confirm working group principles that will drive us toward solutions.

## Address Questions on New Data Added to Appendix 1

- Discuss questions on newly added Appendix 1 data and confirm list of areas needing additional data collection and study

## Finalize Refined Problem Statements

- Confirm and finalize list of Problems/Challenges and priority order

## Discuss Priority Strategies & Potential Recommendations

- Review refined list of priority strategies

## Reminder: Purpose & Goals - Health Care System Planning (HCSP)

- 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

# Working Group Principles (Revised)

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. Ensure **equitable, high quality, affordable access to healthcare for all**, without overburdening providers or diminishing patient experience.
2. **Focus on solutions and root causes** - avoid too much study, identify actions
  - **Prioritize** – identify and focus on the highest priority items
  - **Address underlying issues** to avoid replicating challenges
  - **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
  - Ensure quick fixes consider root causes and don't perpetuate existing inequities
4. **Stay in the hospital sector “lane”** - but identify cross cutting and/or overlapping priorities that need to be tackled in other workgroups.
  - Maintain a **system and statewide lens for solutions** - focus on what the state and system as a whole should do, not individual hospitals
5. **Maximize federal participation** – leverage match, enhanced match, whenever possible.
  - Where additional federal funding is identified, ensure it doesn't displace existing State funding
  - Collectively aim to **keep healthcare revenues in the healthcare sector**
6. Strive to **support the creation of high-quality, well-paid positions** with comprehensive benefits

*For Discussion:*

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

# Priority Solutions Survey

- We received **25 survey responses** out of 36 workgroup members – Thank you!!
- Results of the survey have **informed our draft list of priority strategies** for the Hospital Workgroup
- Many comments informed **refinements to specific strategies and our overall approach**

*“Echoing my previous comments about the **need for more patient- and community-centered perspectives** before this list of strategies is finalized and makes its way into the final recommendations. I can't emphasize enough how much of **a difference truly patient-centered hospital systems can make in a patient's or family's experience** of or even perception of effectiveness.”*

*“I'd like to share some **hesitance about our subgroup calling primarily for increased State investments into hospital reimbursement rates**. We are working in a context in which there are also subgroups for primary care, social determinants of health, behavioral health, etc. If we all come back to the main planning group and all call for more investments for "our" sector, I fear that won't be very productive for anyone. I think **the whole system would benefit from more reliable, consistent, and transparent data about rates, financial health of providers, etc.**”*

*“The strategy, if justified by the data, should be to **develop a reimbursement structure that rewards the best performers, however defined, better than the worst performers**. To the extent that is what is intended by the various payment “strategies” it isn't very clear.”*

*“Stay focused - do 2-3 things really well instead of 12-15 not well.”*

*“There are **opportunities to reduce administrative costs...shared utility for back-office functions...which I don't believe was covered in the strategies.**”*

*“Documenting my support for **hospital fiscal transparency and performance monitoring...We need this capacity now. We are flying blind as a state without comprehensive data on hospital financial performance, revenues, costs, and quality performance. We also need notice requirements and regulatory review of physician group practice acquisitions.**”*

Reference Appendix 3 for a complete list of comments received from working group members through the Priority Solutions Survey

# RI Hospital Sector Starting Point & National Landscape Review

## Information added to this Appendix based on workgroup requests:

1. Overview of National Landscape (high-level national trends/challenges) (Slide 33)
2. RI Outmigration of Services (from Manatt/OHIC Data Hub) (Slide 36)
3. 2023 Operating Margins by payor by hospital/system using NASHP Hospital Cost Tool (Slide 39)
4. Preliminary HCSP Workforce Recommendations (Slides 60-61)
5. Additional slides on the consolidation and financialization of healthcare to address interest in national trends of private equity (Slide 53-56)

## Additional Requests

*(to be Incorporated if time/resources allow)*

- a. Integration of physician practices into hospital networks
  - Local data over time (e.g., owned, affiliated, unaffiliated physicians out of total network)
  - Role of hospital systems in delivery of primary care i.e., physician satisfaction, recruitment, retention. Affiliated vs unaffiliated practices (here or nationally)
- b. Historic merger/conversion results in RI:
  - Cost and quality outcomes
  - Local hospital conversion reviews
- c. Rates: Study of Medicare Advantage rates
- d. Access: Assessment of local provider/physician access
- e. Hospital costs: direct patient care costs and administrative costs, overtime
  - Assess the relative administrative infrastructure at both local hospitals and insurers and the impact on state's ability to compete regionally.

## 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. Review Refined Problem Statements & Priorities

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# Review Refined Problem Statements & Priorities

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- **Today's Objective: Fatal Flaws Review**

- Confirm Meeting #1 and/or Survey feedback is reflected in refined problem statements
- Anything still missing or misstated?
- Agree to finalize problem statements and priority problems.

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

# REVISED Problem Statement Summary\* – Priority A

Problem Area	Sub-Categories	Key Elements Noted by Participants*
<b>Priority A Problem Areas</b>		
<b>#1: Lack of Statewide Health System Oversight, Data Infrastructure, and Long-Term Planning</b>	<b>Statutory &amp; Regulatory Framework</b>	Lack of <b>statewide health system data collection, governance, and long-term vision</b> to inform planning
		<b>Crisis has not been adequately identified</b>
		Specialized <b>capacity for new services has been built without sufficient demand</b> to deliver them efficiently
		Lack of <b>multi-payor regulatory/oversight processes</b> ( <i>including Medicare Advantage – prior auths/denials</i> )
		Hospital system <b>silos limit collaboration on best practices</b> that address system-wide challenges
<b>Fiscal Monitoring &amp; Oversight</b>	Limited <b>private equity guardrails in other sectors</b> ( <i>physician practices, urgent care centers, nursing homes</i> )	
	Limited focus on <b>statewide health equity</b> and patient- and community-centered perspectives	
<b>#2: Reimbursement Not Keeping Pace with Rising Costs</b>	<b>Wages &amp; Benefits</b>	Reimbursement as it relates to <b>wages</b> ( <i>pay, residency costs, cost of living</i> )
	<b>Other Hospital Administration Operations</b>	<b>High admin infrastructure and overhead costs driven by small scale</b> ( <i>denials, malpractice, physician subsidies</i> )
		Claims <b>denials and prior authorizations</b> ( <i>especially Medicare Advantage</i> )
		Medical supplies, <b>drug costs</b>
	<b>Payment &amp; Reimbursement</b>	Not <b>maximizing federal match</b> ( <i>e.g., hospital tax, MCO tax</i> )
		<b>Payer mix</b> ( <i>heavy Medicaid, high Medicare Advantage penetration</i> )
		<b>Reimbursement adequacy and predictability concerns</b> ( <i>especially Medicaid with supplemental payments</i> )
<b>Negotiated fees</b> ( <i>inconsistent market power of hospitals</i> )		
<b>VBP</b>	<b>Hospital cost accountability and payment reform</b> ( <i>interest in global budgets, concerns VBP may not be working</i> )	
<b>#3: Limitations in Investment &amp; Technology</b>	<b>Access to Capital</b>	<b>Insufficient margins</b> to generate capital for investments
		Limited access to <b>capital markets/capital improvements</b>
		<b>Regulatory constraints</b> to market consolidation ( <i>especially across borders</i> )
	<b>Technology</b>	<b>Size/scale limitations</b> ( <i>challenging to manage investments as "small " systems</i> )
		Lack of <b>interoperable clinical-centered EMR design</b>
	<b>Cybersecurity risks</b> – lack of thought leaders in state and hospital systems	
	<b>Small independent insurers</b> have limited ability to invest in data management systems that can help hospitals	

\* See Meeting #2 Appendix 2. Detailed Problem Statements & Preliminary Solutions Version 3 (Word Doc, separate attachment) for additional details. Appendix provides detail into all draft problem statements and solutions.

# REVISED Problem Statement Summary\* – Priority B

Problem Area	Sub-Categories	Key Elements Noted by Participants*
<b>Priority B Problem Areas</b>		
<b>#4: Workforce</b>	<b>Physician, Nursing &amp; Tech Shortages</b>	<b>Lack of access to physicians/specialists</b> – patients are waiting several months to get an appointment
		<b>Cuts to CNA positions</b>
	<b>Strategic Workforce Planning</b>	<b>RN, ancillary staff shortages</b> – fewer nurses interested in pursuing careers in the industry, insufficient supports
		<b>Lack of clear and robust career ladder</b> from CNA to LPN or RN
<b>Physician Partnership</b>	Limited <b>hands-on training/apprenticeship opportunities</b> (leading to faster burnout)	
<b>#5: ED Utilization, Primary Care Capacity and Prevention</b>	<b>Community Access</b>	Limited <b>surgical and diagnostic imaging Technologists and Technicians</b>
	<b>Primary Care/Alternatives</b>	Limited hospital wide workforce planning, career path development & <b>utilization of state workforce programs</b>
		Lack of engagement and <b>partnership between hospital leadership and physicians/specialists</b>
	<b>Behavioral Health &amp; HRSN</b>	<b>Insufficient access to community settings</b> limited by language, after-hours, dental and BH capacity
		Lack of <b>Primary Care Capacity</b> / Investment in primary care
Inadequately <b>leveraging FQHCs</b> to reduce ED use		
<b>Urgent Care</b> , ED locations		
<b>Lack of HRSN navigators</b> /supports		
<b>Early and pending investments in CCBHC and mobile crisis</b> - community BH alternatives		
<b>Challenges with ED triage</b> , especially for patients with BH needs		
<b>#6: Length of Stay and Care Transitions</b>	<b>Patient Complexity</b>	<b>High acuity patients</b> /long lengths of stay
	<b>Community Alternatives</b>	Financial fragility of <b>community settings</b> - lack of home care workforce
		<b>Underprepared for rapidly aging population</b> - lack of focused investment in community-based services for elders
	<b>Physician Training</b>	Lack of <b>BH step down</b> options (especially ICF/IDs)
	<b>Discharge Planning</b>	Lack of <b>nursing home beds</b>
	Lack of sufficient <b>palliative care training</b>	
	Lack of standardized approach to <b>managing care transitions</b>	

\* See Meeting #2 Appendix 2. Detailed Problem Statements & Preliminary Solutions Version 3 (Word Doc, separate attachment) for additional details. Appendix provides detail into all draft problem statements and solutions.

# III. Deep Dive on Priority Strategies

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# Deep Dive on Priority Strategies

- **Today's Objectives**

- Review draft list of Top 7 priority strategies
- Discuss each of the priority strategies in detail to identify further refinements or additions needed
- What are the potential unintended consequences of the strategies we are pursuing?

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

# Emerging Strategies

A combination of “repair” strategies can be taken immediately; however, these strategies are necessary but likely not sufficient – systematic, data informed, community driven redesign is needed

### Immediate Action

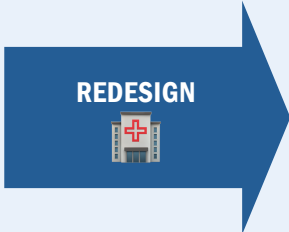


**Immediate action is needed to tackle the costs, revenue and infrastructure/investment capacity of Rhode Island’s hospitals and health systems**

- Hospital efficiency / cost reduction strategies
- Revenue enhancement strategies
- Infrastructure investment pathways

**These strategies are likely necessary but not sufficient to address the identified problems/challenges**

### Longer-term Action



**Longer term, new approaches are needed to drive significant transformation at the state, system and hospital levels**

- Preplanned, data informed, community driven transformation
- Systematic redesign: consider repurposing facilities, focus on vulnerable/at risk communities
- Supporting regulatory and oversight models

### Supporting Action

**Supporting action is required, within and beyond the scope of hospitals, to address the underlying drivers of hospital fiscal and operational performance**

- Primary Care & HRSN
- Behavioral Health
- Long-term Services and Supports
- Health Care Workforce will need to expand inside & outside hospitals to support health system goals

*These cross-cutting strategies must be tackled across sectors/working groups. Preliminary suggestions included here.*

# Emerging Priorities: Top 7

*Top goals are not in any particular order – numbers are for ease of reference only*

## Immediate Action

REPAIR



1. **Establish Hospital/Health System Fiscal Transparency & Performance Monitoring (with equity lens):** (a) Perform initial analysis & build state infrastructure/capacity; (b) Seek Medicaid 1115 Waiver authority to support fiscal stability; (c) Tackle hospital operating costs/efficiency through statewide learning collaborative
2. **Medicaid Payment:** (a) Maintain state directed payments while performing a comprehensive rate study; (b) Based on study, maximize hospital tax to directly adjust Medicaid rates and/or leverage alternative sources of funds (e.g., savings from state health plan) (c) State-wide, coordinated rate reform

## Longer-term Action

REDESIGN



3. **Develop a Statewide Acute Care Plan informed by a deep dive analysis of Statewide Capacity & Needs** - Consider RI specific vs regional capacity, hospital vs. alternative structures, health equity and geographic differences
4. **Restructure Oversight of Mergers and Hospital Conversion**
5. **Reform CON Process** - Increase \$ threshold; enforce conditions on approval

## Supporting Action

6. **Invest in High Quality Primary Care Practices** - take the burden off hospitals to support primary care and ensure the funds stay within primary care
7. **Support Targeted Gaps in Hospital Workforce** – through scholarships, incentive-based programs, and community partnerships

# Immediate Action: Repair #1 (a)

## 1 (a) Perform initial analysis & build state infrastructure/capacity for ongoing Hospital Fiscal Transparency & Performance Monitoring (with equity lens)

- **Authority:** Leverage existing EOHHS and RIDOH authority - Build in authority to hire independent auditors at the expense of the hospitals to support comprehensive assessment of private equity and other investor-based organizations with complex/opaque financial structures. Ensure mechanism is in place to enable full access to both for-profit and nonprofit hospital finances/data.
- **Components:** Create baseline analysis/initial dashboard of a) hospital and health system fiscal stability b) operational/efficiency metrics and c) system and population characteristics including disparities in health outcomes by geography, race/ethnicity, gender; hospital bed capacity and ED boarding.
- **Process & Structure:** Implement data governance for hospital and health system financials that incorporates hospital input 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 and incorporate patient-centered perspective of patients and community members.
- **Compliance:** Incorporate meaningful financial transparency compliance rules (quarterly reporting of health system/parent company financials), with stringent consequences for non-compliance (i.e., Medicaid funding cuts).
- **Use:** Treat fiscal oversight like a bond holder, with defined triggers for intervention (e.g., establish audit requirements based on days of cash on hand (50 days, 30 days)). Consider employing risk-based classification of health systems (red/yellow/green) that can be tied to tiered merger/acquisition oversight requirements (e.g., increased oversight for at-risk entities, reduced/minimal oversight for financially sound entities).
- **Scope:** Consider broader application of financial transparency and monitoring requirements beyond hospitals to include physician practices, FQHCs, and nursing homes.
- **Funding:** Leverage portion of hospital tax to fund ongoing state infrastructure.

# Immediate Action: Repair



## #1 (b)(c)

### 1 (b) Seek 1115 Waiver authority and funding to support findings from hospital fiscal monitoring

- Authority: Seek DSHP/CNOM authority to authorize federal match for current state university health workforce expenditures
- Use: 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
  - 4) Added workforce investments

### 1 (c) Tackle hospital operating costs/ efficiency

- Establish pathway & funding for **hospital learning collaborative** on best practices in hospital operations to identify pathways to reduce administrative costs (e.g., billing codes, leveraging the health information exchange, EMRs, centralized back-office infrastructure, etc.)
- Document and share relevant learnings with community partners (e.g., assistance with Medicaid billing)

# Immediate Action: Repair #2

## 2 (a) Medicaid Payment – Step 1

- **Study:** Conduct a comprehensive hospital, primary care, and 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.
- **Protect:** Maintain state directed payment/one-time payment mechanisms to protect hospitals while studies are completed
- **Funding:** Leverage hospital tax – Increase hospital tax in line with CMS rules for existing redistributions of provider taxes to fold back into provider system. Consider pursuing statutory authority to protect funds, however this approach could risk CMS review. Monitor/follow new federal guidance and restrictions. Potentially leverage alternate or supplemental sources of funds (e.g., savings from state health plan).

## 2 (b) Medicaid Payment – Step 2

- **Rates:** Adjust Medicaid payment rates based on results of comprehensive rate study, comparative to Medicare, other states. Transition state directed payment, other one-time hospital payment mechanisms into rate adjustments – predictable source of funds
- **Funding:** Leverage increases to hospital tax - represents Medicaid share of increase, without any added state budget (if allowable).
- **Application:** Consider tiered/differential payments tied to participation in AHEAD or other pay for performance goals (fiscal monitoring/quality measures). Incorporate additional infrastructure supports for hospitals to support this model (see funding and infrastructure solutions).

## 2 (c) Medicaid Payment - Step 3

Consider **state-wide, coordinated rate reform and alignment**. For example:

- Consider increasing **Medicaid hospital & physician rates to match Medicare** to improve inequities in access for Medicaid patients.
- Consider **an all-payer standardized rate** for hospital services, based on the [Maryland model](#).

# Longer-term Action: Redesign

REDESIGN



#3

III. Priority Strategies

## 3. Develop a **Statewide Acute Care Plan based on a deep dive analysis of capacity and needs** (every 5+ years)

- **Use:** Plan to provide a roadmap to inform infrastructure investment decisions, CON process reforms.
- **Authority:** Leverage existing Office of Health System Development, RIDOH authority. Consider consolidating responsibilities that are currently spread across state agencies to drive strategic healthcare planning.
- **Components:** this plan must:
  - Identify **where/what acute care services** are needed, including bed capacity, RI specific vs regional capacity,
  - Prioritize **service capacity for vulnerable communities**, considering health equity and geographic differences,
  - Specify **hospital vs. alternative community capacity** options for specific geographies, e.g.,
    - (1) Repurposing facilities/staffing at risk hospitals to provide care thru different models, like the CMS rural health model;
    - (2) 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;
    - (3) Specialty Congestive Heart Failure (CHF) chronic care centers in vulnerable communities and resource with teams of providers (NPs, dieticians, PAs etc.) inclusive of remote monitoring, team home visits and treatment centers for patients with chronic diseases
  - Identify where/when to transition to **centralized technology**
- **Community Engagement:** Process to incorporate patient-centered perspective of patients, community members
- **Starting Point:** Ensure hospital community health needs assessments are leveraged. Potentially leverage/build on Statewide Health Inventory study – currently an unfunded legislative mandate.
- **Funding:** Leverage portion of hospital tax to fund this analysis on an ongoing basis as needed (every 5+ years)

# Longer-term Action: Redesign

REDESIGN



# #4 & 5

III. Priority Strategies

## 4. Restructure Oversight of Mergers and Hospital Conversion

- Expand Scope: Consider expanding Hospital Conversion Act beyond hospitals to leverage these guardrails on private equity investments in other sectors (physician practices, urgent care) that focus on preventing harms and negative outcomes, so that “returns on investment” don’t detract from patient care
- Limit Application: Reduce regulatory barriers to non-profit mergers and out of state alignments for entities with strong fiscal stability – as they limit critical operational and fiscal improvements
- Reduce administrative burden of hospital conversion review process. 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.

## 5. Reform CON Process

- Transform/enhance CON process to be based on long-term health system plan 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.
- Conditions of Approval: Implement, monitor, and enforce conditions on approval to ensure intended outcomes are attained. Fund state resources to monitor these conditions.

# Emerging Priorities: Supporting Action

## 6. Invest in High Quality Primary Care Practices

- Purpose: State could play a role in taking the burden off hospitals to support primary care and ensure the money stays within primary care. Hospitals control the majority of primary care, but don't have the margins to support.
- Assessment: Consider including primary care practices and FQHCs in financial transparency and monitoring initiative (#1) to assess targeted gaps in financial performance and operational efficiency and identify high performing, high quality practices.
- Payment: Ensure appropriate incentives are in place to reward efficiency and drive quality outcomes (e.g., APM to support physician productivity).

## 7. Support Targeted Gaps in Hospital Workforce

- Implement scholarship/incentive-based programs to encourage more diagnostic imaging and medical lab technologists
- Establish additional Surgical Technologist Associate Programs in the area – currently only one program at NEIT
- Partner hospitals with community-based workforce development providers (e.g., Genesis Center, RI Nurses Institute Middle College) to address these gaps and connect them to untapped community capacity.

*These cross-cutting strategies must be tackled across sectors/working groups*

# Review Next Steps



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## Next Steps

- **Thursday, October 17<sup>th</sup>**
  - We will send meeting minutes, revised problem statements and priority solutions (as needed)
- **Next Meeting: To be scheduled, tentatively November 4<sup>th</sup> - 6<sup>th</sup>**
  - Objective: To Confirm priority strategies and recommendations to include in final report
- **HCSP Cross-Sector Retreat: November 7<sup>th</sup>**
  - Location: RI Nursing Education Center, 350 Eddy Street, in Providence
  - Agenda and timing to be finalized and shared shortly
- **Send us any/all feedback: problems/solutions, data/research needs, SMEs, additional ideas**

Any questions, feedback or ideas to share? Email/Text/Call  
Jess Brown, [jbrown@faulknerconsultinggroup.com](mailto:jbrown@faulknerconsultinggroup.com) (401)-330-8155  
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# Appendices

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<b>Appendix 1</b>	<b>RI Hospital Sector Starting Point &amp; National Landscape Review</b>
<b>Appendix 2</b>	<b>Detailed Problem Statements &amp; Preliminary Solutions</b>
<b>Appendix 3</b>	<b>Comments for Workgroup Consideration, based on Hospital Workgroup Priority Solutions Survey</b>
<b>Appendix 4</b>	<b>Broader Cabinet Reference Materials</b>

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

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## 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<sup>1</sup>
- 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. Industry Consolidation and Financialization/Private Equity:** National learnings
- F. Workforce & EMR:** Local Starting Point

*1. Operating margins by payer for RI hospitals have been included in the local starting point data for reference, however, please note there are conflicting views from workgroup members as to the accuracy of these data*

# A. Overview – National Hospital Landscape

<b>Sector Structure</b>	<ul style="list-style-type: none"> <li>The 2024 AHA annual survey reported 6,120 hospitals in the United States<sup>1</sup></li> <li>The U.S. hospital sector is a mix of non-profit (58%), for-profit (24%), and government-owned facilities (18%)<sup>1</sup></li> <li>The sector includes general acute care hospitals, specialty hospitals, and long-term care facilities.</li> </ul>
<b>Financial Outlook</b>	<ul style="list-style-type: none"> <li><b>COVID-impacted margins:</b> Operating margins decreased by a large amount between 2021 and 2022.</li> <li><b>Recent improvements:</b> After persistent negative margins, US hospital operating margins improved in 2023 and were up 4.9% YTD as of August 2024<sup>5</sup>; however, margins tend to remain below pre-pandemic levels.</li> <li><b>Target:</b> 2-3% is often noted as the minimum operating margin needed to maintain existing investments in infrastructure and technology<sup>6</sup>, but collective margins have not yet returned to that level.</li> <li><b>Scale:</b> Smaller hospitals are more likely to face financial struggles - particularly those with annual revenues under \$500M.</li> </ul>
<b>Key Trends &amp; Challenges</b>	<ul style="list-style-type: none"> <li><b>Consolidation &amp; Financialization.</b> An increasing share of hospitals are merging or being acquired by larger health systems to gain economies of scale, and an increasing share of physicians are affiliated with hospitals or health systems.<sup>2</sup> The number of for-profit hospitals is growing every year, as more nonprofit hospitals are exploring potential transitions to an investor-owned financial model.</li> <li><b>Payor mix.</b> Population shift out of commercial insurance into Medicare, described as the "greatest long-term impact to future net hospital revenue"<sup>4</sup></li> <li><b>Reduced Safety Valve.</b> Due to the end of stimulus funds and reimbursement enhancement from public health emergencies</li> <li><b>Shift to outpatient care.</b> Shifts to outpatient settings, coupled with changing Medicare payment rules has left more complex patients in costly inpatient settings with unfavorable reimbursements<sup>3</sup></li> <li><b>Technology investment.</b> Hospitals are increasingly implementing electronic health records (EHRs) and telemedicine services.</li> <li><b>Staffing shortages &amp; labor costs.</b> Many facilities are struggling with shortages of nurses and other healthcare professionals.</li> <li><b>Population mix .</b> An aging population with increasing complexity is requiring more care; sicker patients (less healthy Americans)</li> <li><b>Payor practices.</b> Significant growth in operating costs driven by increasing claims denials, onerous prior authorization requirements<sup>3</sup></li> </ul>

1. AHA Data Hub, 2022 US Hospitals.

2. KFF. "Ten Things to Know About Consolidation in Health Care Provider Markets". April 2024.

3. AHA. "Costs of Caring". 2024.

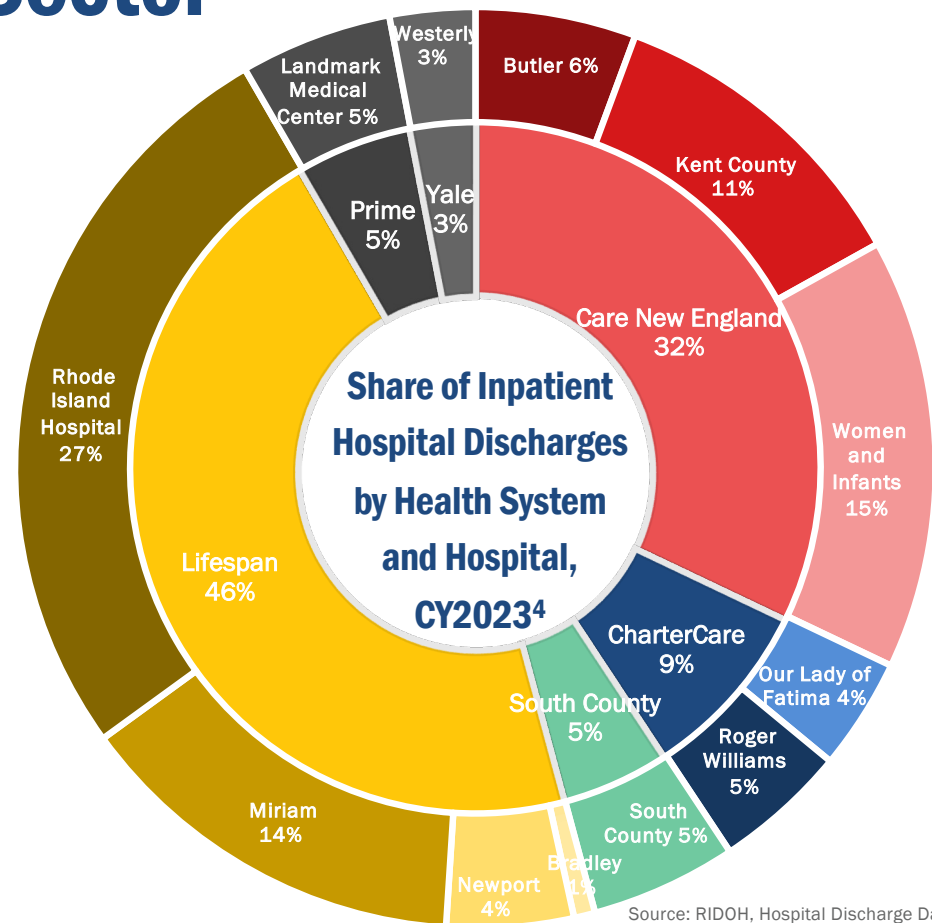
4. Oliver Wyman. "[7 WAYS HOSPITALS CAN CUT COSTS, ACHIEVE LONG-TERM STABILITY](#)". 2024.

5. Strata. "Monthly Healthcare Industry Financial Benchmarks". 2024.

6. FCG researching

# A. Overview - RI Hospital Sector

- Rhode Island has 7 hospital systems<sup>1</sup> and 16 hospitals, including:
  - 10 acute care hospitals
  - 3 psychiatric hospitals<sup>2</sup>
  - 2 rehabilitation hospitals
  - 1 long term acute care hospital<sup>3</sup>
- The hospital system with the largest volume by discharges in CY 2023 was Lifespan with 46%, followed by Care New England with 32%.
- Note as of October 8<sup>th</sup>, 2024 CharterCare’s application for a change in effective control review process was accepted



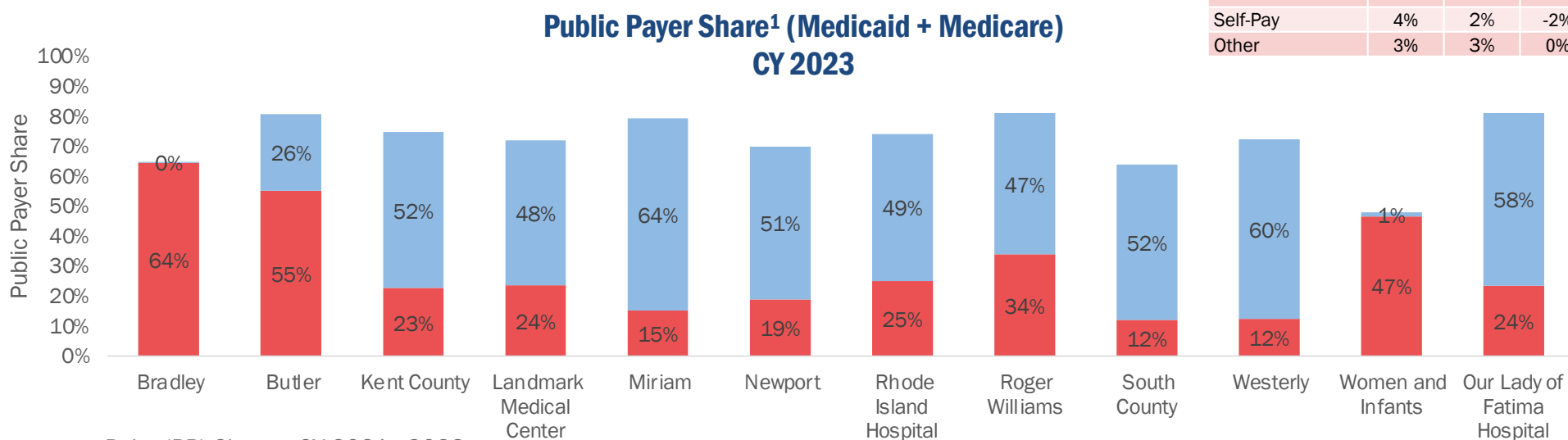
Source: RIDOH, Hospital Discharge Data, CY2023

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. 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%
<b>Public Payer Total</b>	<b>68%</b>	<b>71%</b>	<b>3%</b>
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%
<b>Total Public</b>	<b>1%</b>	<b>3%</b>	<b>13%</b>	<b>-1%</b>	<b>1%</b>	<b>0%</b>	<b>1%</b>	<b>1%</b>	<b>4%</b>	<b>1%</b>	<b>4%</b>	<b>1%</b>

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

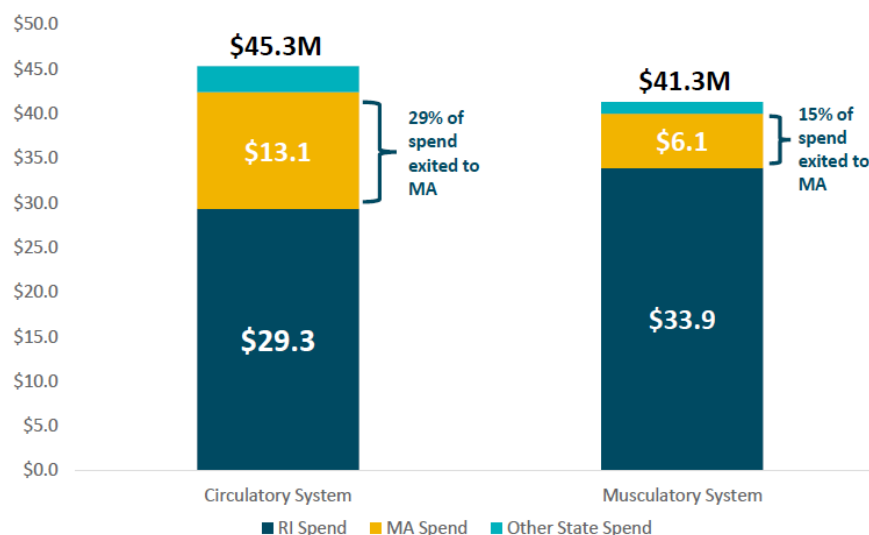
# A. Overview – Outmigration of Services



## RI Commercially-Insured Patient Outmigration to MA for Inpatient Care (2021)

Each year, RI patients seek care from health systems in other states, or “migrate” to receive care. A recent RI OHIC care migration review found that cardiovascular and orthopedic inpatient services comprised over \$19M in 2021 spending for commercially-insured RI patients who left the state to receive inpatient care at MA providers.

Total 2021 Spend for Commercially-Insured RI Patients by Major Diagnostic Category and State Where Care Was Provided



### Top 3 Cardiovascular higher cost DRG commercial volumes out-migrating to MA:

- Percutaneous coronary intervention (PCI) with acute myocardial infarction (AMI)
- Cardiac valve procedures without AMI or complex principal diagnosis (PDX)
- PCI without AMI
  - These 3 DRGs represented \$4.2M in MA spend
  - These 3 DRGs’ price per unit (PPU) ranged from 21 – 26% higher in MA, when compared to RI PPU

### Top 3 Orthopedic higher cost DRG commercial volumes out-migrating to MA:

- Dorsal & lumbar fusion procedure except for curvature of the back
- Elective knee joint replacement
- Elective hip joint replacement
  - These 3 DRGs represented \$3.3M in MA spend
  - These 3 DRGs’ PPU ranged from 7.5% (knee replacement) to 20.6% (dorsal & lumbar fusion ) higher in MA, when compared to RI PPU

For further information on employer-sponsored health plan pricing to hospitals, please refer to Section 5.

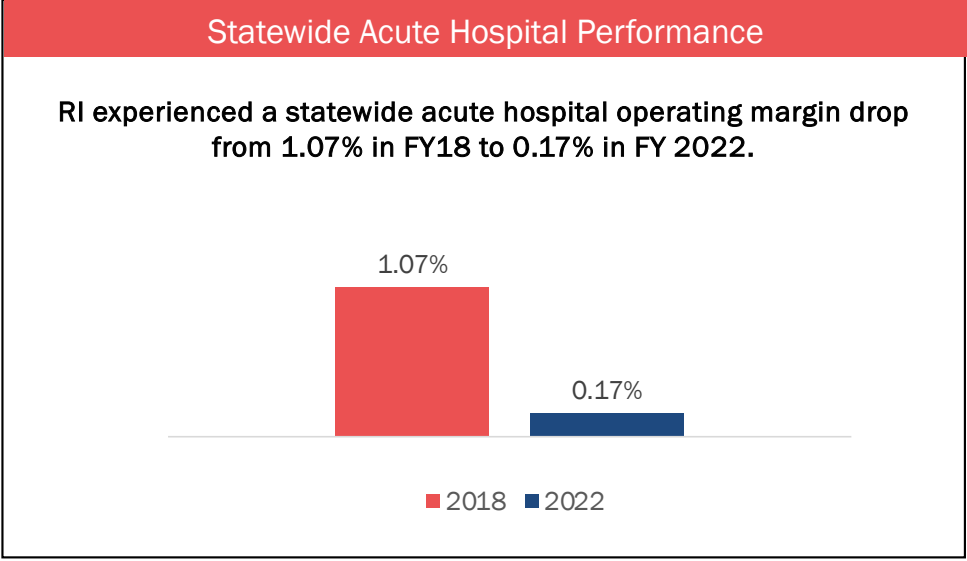
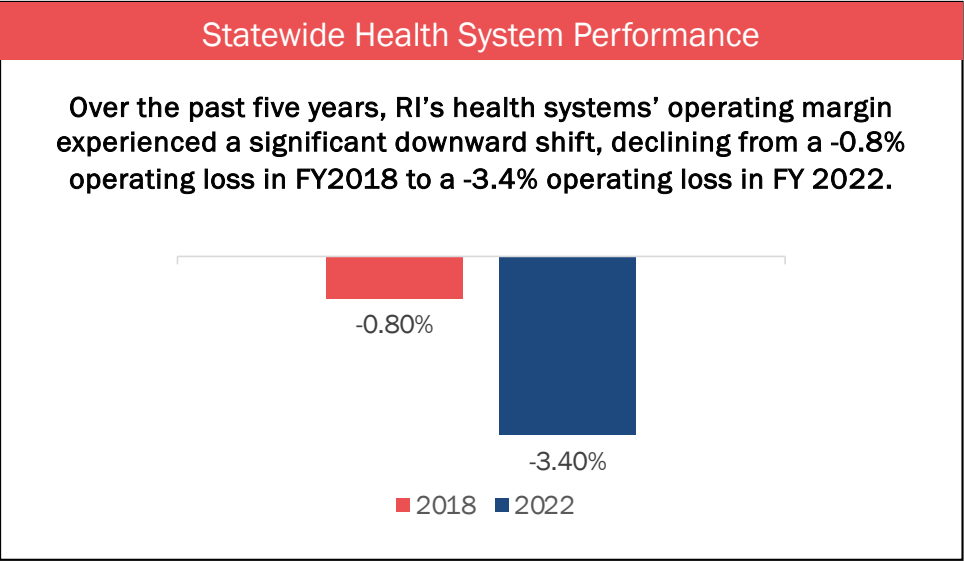
Note: The R All Payer Claims Data (APCD) does not contain data from all self-insured employers. The total spending and proportion by state reflects the insured groups that contribute to the APCD.

Source: RI OHIC Internal Report, “Summary Analysis of 2021 Care Migration Patterns” (2023)

# 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)



# 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%
<b>Total RI Health Systems</b>	<b>\$4,745,563,669</b>	<b>\$4,907,722,287</b>	<b>-\$162,158,618</b>	<b>-3.4%</b>

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.

# A. Overview – Health System Financial Performance

Operating profit margin by payor type, as reported by the NASHP Hospital Cost Tool (2022)<sup>1</sup> appears to vary considerably by hospital and payor type; however, some committee members noted concerns with the NASHP methodology & findings

## 2022 Operating Margin by Payor<sup>1</sup>

Health System	Hospital	Commercial	Medicaid	Medicare	Medicare Advantage
Care New England	Kent Hospital	-17%	-1%	-2%	2%
	Woman & Infants	22%	4%	-31%	-26%
CharterCare	Roger Williams	-182%	5%	18%	21%
	Our Lady of Fatima	-19%	8%	-7%	-3%
Lifespan	Newport Hospital	22%	-16%	-9%	-5%
	Rhode Island	18%	-12%	15%	19%
	The Miriam	8%	-48%	13%	16%
Prime Healthcare	Landmark	2%	6%	25%	28%
South County Health	South County	45%	-53%	-12%	-8%
Yale New Haven	Westerly	31%	-60%	-10%	-6%

### Key Takeaways

Sizable performance variation across hospitals and payors

- Landmark: positive margins across payors despite high public payor mix
- Medicaid losses across multiple hospitals – with a few notable exceptions
- Positive commercial margins across most hospitals – with a few notable exceptions

#### Notes:

- 2022 was the worst financial year for hospitals and health systems since the start of the COVID 19 Pandemic, with approximately 50% of US hospitals closing the year with negative operating margins as growth in expenses outpaced revenue increases<sup>2</sup>

1. NASHP Hospital Cost Tool, Hospital Level Data Set, July 2, 2024. <https://tool.nashp.org/>

2. AHA, Kaufman Hall Report: 2022 worst financial year for hospitals since start of pandemic, Jan 2024

# 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

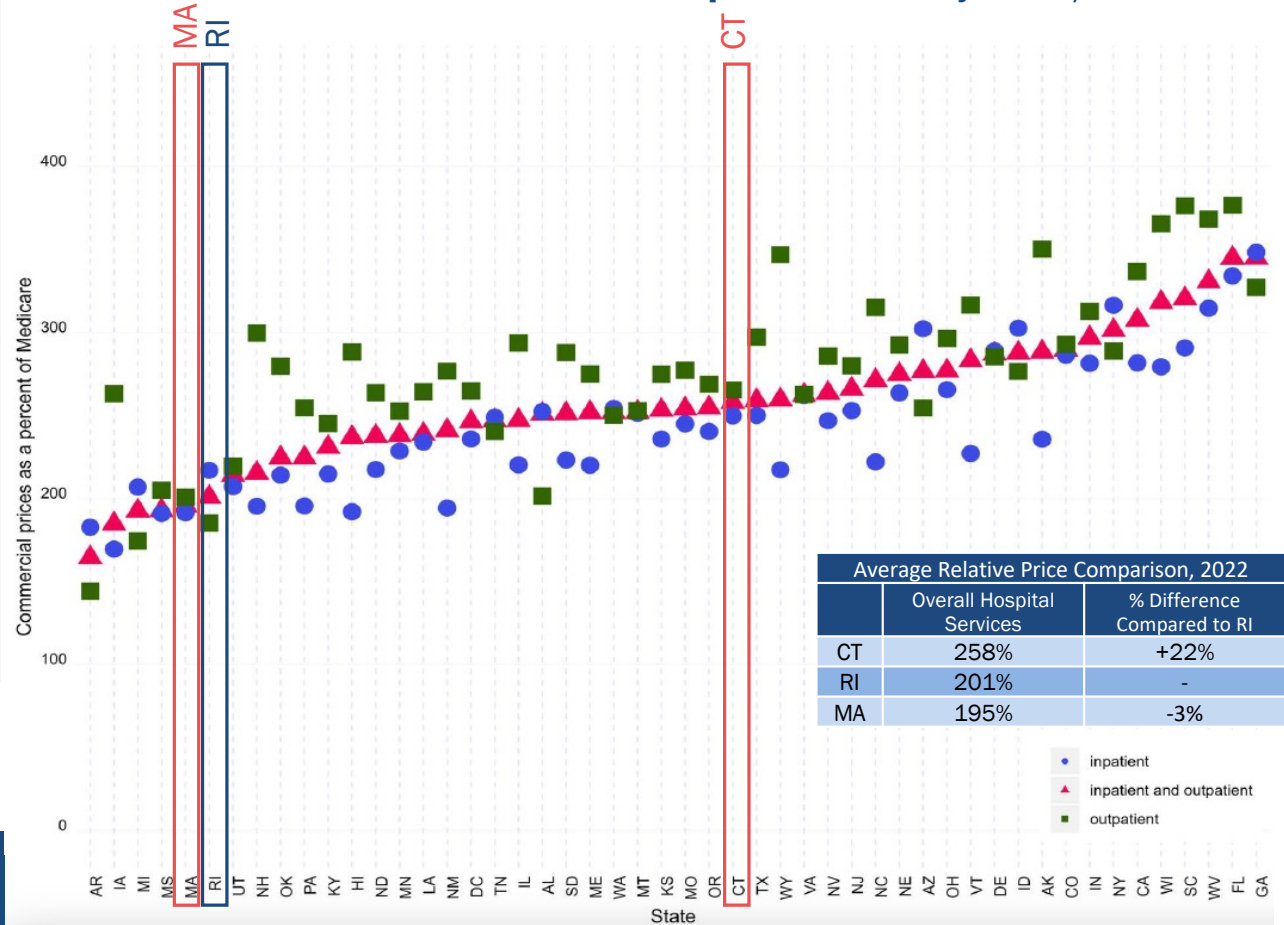
**Relative Price:** The ratio of the actual private/commercial allowed amount divided by the Medicare allowed amount for the same services provided by the same hospital

- 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

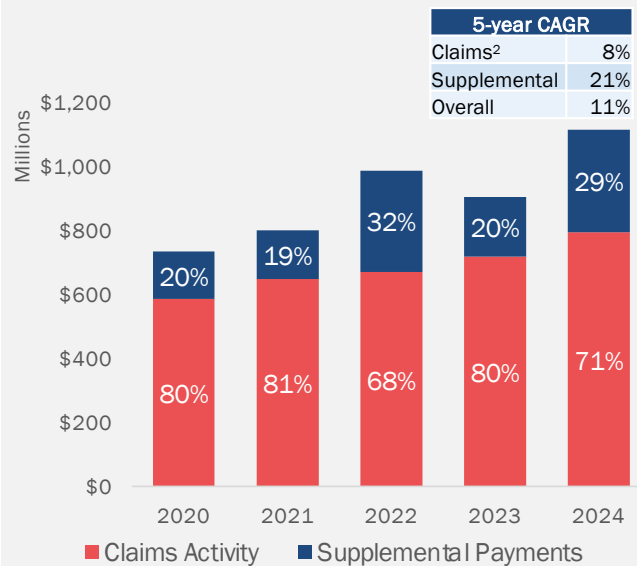


# B. Payment - Medicaid Hospital Expenditure

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.

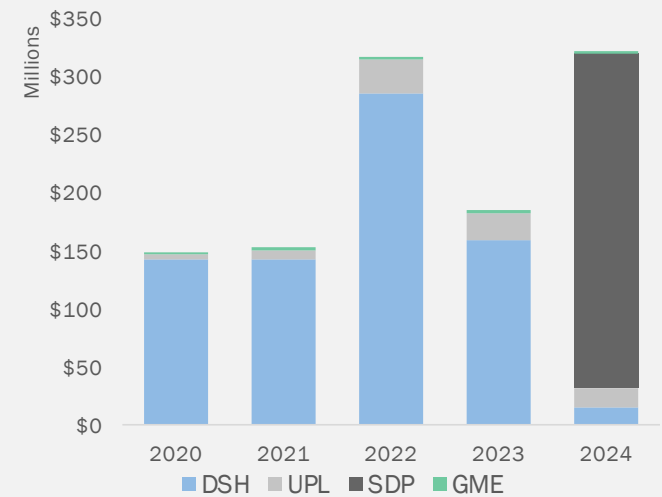
- RI uses a combination of supplemental payment types, including Disproportionate share hospital (DSH) payments, Upper Payment Limit (UPL) payments, Graduate Medical Education (GME) payments for teaching hospitals, and as of this year State Directed Payments (SDP).
- Historically, DSH payments constituted 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<sup>1</sup>**



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.

## B. Payment - RI Supplemental Payment Types Detail

Payment Type	Payment Goals	Relationship to Other Payments	Additional Notes
<b>Disproportionate Share Hospital (DSH) Payment</b>	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.
<b>Upper Payment Limit (UPL) Payment</b>	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.
<b>State Directed Payments (SDP)</b>	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.
<b>Graduate Medical Education (GME) Payment</b>	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.	

## C. Investment - New CMS Rule re: Provider Taxes

- On September 9<sup>th</sup> 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<sup>1</sup>:

- 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

Basis of payment	Categories of cost					
	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	✓	✓	✓	✓		
<b>5. Global budgets</b>	✓	✓	✓	✓	✓	
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>

## 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 DSHP 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
<b>Vital Access Providers Assurance Program (VAPAP)</b>	<b>\$2,404,793,968</b>
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
<b>Total Allowable DSHP-Eligible Expenditures</b>	<b>\$4,323,664,110</b>
<b>Total DSHP Cap.</b>	<b>\$3,981,442,500</b>

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
<b>Arizona</b>	Acute Hospitals, Non-Acute Hospitals, Psychiatric Hospitals, Nursing Homes, Hospice Facilities,	Audited Financial Statement, Audited Financial Statement Consolidating Schedule, Medicare Cost Report, Chargemaster
<b>California</b>	Acute Hospitals, Non-Acute Hospitals, Psychiatric Hospitals, Nursing Homes, Hospice Facilities, Intermediate Care Facilities	Chargemaster
<b>Colorado</b>	Acute Hospitals	Audited Financial Statement, Audited Financial Statement Consolidating Schedule, Medicare Cost Report, IRS Form 990
<b>Florida</b>	Acute Hospitals, Non-Acute Hospitals, Psychiatric Hospitals, Nursing Homes, Hospice Facilities, Intermediate Care Facilities	Audited Financial Statement, Audited Financial Statement Consolidating Schedule
<b>Georgia</b>	Acute Hospitals (Non-Profit only)	Audited Financial Statement, Audited Financial Statement Consolidating Schedule, IRS Form 990
<b>Indiana</b>	Acute Hospitals	Audited Financial Statement, Medicare Cost Report
<b>Maine</b>	Acute Hospitals	Audited Financial Statement, Audited Financial Statement Consolidating Schedule, Medicare Cost Report, IRS Form 990
<b>Maryland</b>	Acute Hospitals, Non-Acute Hospitals, Psychiatric Hospitals	Audited Financial Statement, Audited Financial Statement Consolidating Schedule
<b>Massachusetts</b>	Acute Hospitals, Non-Acute Hospitals	Audited Financial Statement, Audited Financial Statement Consolidating Schedule, Medicare Cost Report, IRS Form 990, Chargemaster
<b>Missouri</b>	Acute Hospitals	*Missouri does not require any of these “standard” reports, but instead requires other financial data determined by statute and agency rulemaking
<b>New Jersey</b>	Acute Hospitals, Non-Acute Hospitals, Nursing Homes	Audited Financial Statement
<b>Washington</b>	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	<p><b>957 CMR 9.00:</b> 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.</p>	<p><b>House Bill (HB) 19-1001 Hospital Transparency Measures to Analyze Efficacy</b> requires HCPF to develop and publish a report on uncompensated costs of care and the different expenditures made by hospitals in the state.</p> <p><b>HB23-1226 Hospital Transparency and Reporting Requirements</b> expands upon HB19-1001 to create more timely submissions of data; <b>to create additional reporting requirements on transfers of cash, profits, and reserves</b>; to report more executive compensation; and to report mergers and acquisitions of hospitals and physicians.</p>
Process	<p><b>Hospitals must submit to CHIA:</b> annual and quarterly financial reports.</p>	<p><b>Hospitals must submit to HCPF:</b> historic (if available) and recent audited financial statements, Medicare cost reports, historic and recent financial and utilization metrics, acquisition transactions, and affiliation transactions.</p>
Financial reporting non-compliance penalties	<p>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.</p>	<p>The <b>state department shall issue a corrective action plan</b>. If a hospital continues to not comply, <b>the state department may create a mandatory pay-for-reporting compliance measure</b>.</p> <p>If a hospital's noncompliance is knowing or willful or there is a repeated pattern of noncompliance, <b>the state department shall consider the size of the hospital and the seriousness of the violation in setting a fine amount</b>.</p>
How is the state using data to monitor hospitals?	<p><b>Reporting, Cost-Monitoring, Financial Transparency</b></p> <ul style="list-style-type: none"> <li>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</li> </ul>	<p><b>Reporting and Financial Transparency</b></p>

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	<ul style="list-style-type: none"> <li>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.</li> </ul>
	Financials	<ul style="list-style-type: none"> <li>Requires annual submission of audited financial statements, financial position statements, and healthcare service costs.</li> <li>Currently does not take an active role in reviewing financial information</li> <li>Recently engaged a third party to review hospital financial information</li> </ul>
	Charity Care, Uncompensated Care, Community Benefits	<ul style="list-style-type: none"> <li>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</li> </ul>
	Reporting Regulation & Data Distribution	<ul style="list-style-type: none"> <li>Imposes reporting obligations and participates in making data trends public (efforts have been limited due to funding)</li> </ul>
	Inequities and Disparities	<ul style="list-style-type: none"> <li>The Commission for Health Advocacy &amp; 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.</li> </ul>
	Health Care Facility Licensing	<ul style="list-style-type: none"> <li>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.</li> </ul>
	Certificates of Need	<ul style="list-style-type: none"> <li>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.</li> </ul>
EOHHS	Medicaid Payment Reform	<ul style="list-style-type: none"> <li>Broad authority to implement Medicaid payment reform initiatives (subject to CMS approval)</li> <li>No independent authority to review hospital or provider finances outside of Accountable Entities (AE) certification</li> </ul>
	Accountable Entities (AE)	<ul style="list-style-type: none"> <li>Oversees AEs with cost, quality, and performance benchmarks</li> <li>Conducts annual recertification of AEs</li> </ul>
OAG	Hospital Conversions	<ul style="list-style-type: none"> <li>Evaluates financial health and access to care during hospital conversions</li> <li>No general oversight authority over health system costs or providers' financial health</li> </ul>
OHIC	Quality	<ul style="list-style-type: none"> <li>Sets and oversees requirements driving affordable care</li> </ul>
	Cost Containment	<ul style="list-style-type: none"> <li>Focuses on rate caps for hospitals</li> <li>Ensures insurers meet certain spend targets</li> </ul>
Joint	Hospital Conversions	<ul style="list-style-type: none"> <li>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</li> </ul>
	APCD	<ul style="list-style-type: none"> <li>DOH, OHIC, EOHHS, HSRI, and RI Benefits Exchange work together to collect claims data from a variety of payer sources</li> <li>APCD law and regulations fall under DOH</li> </ul>

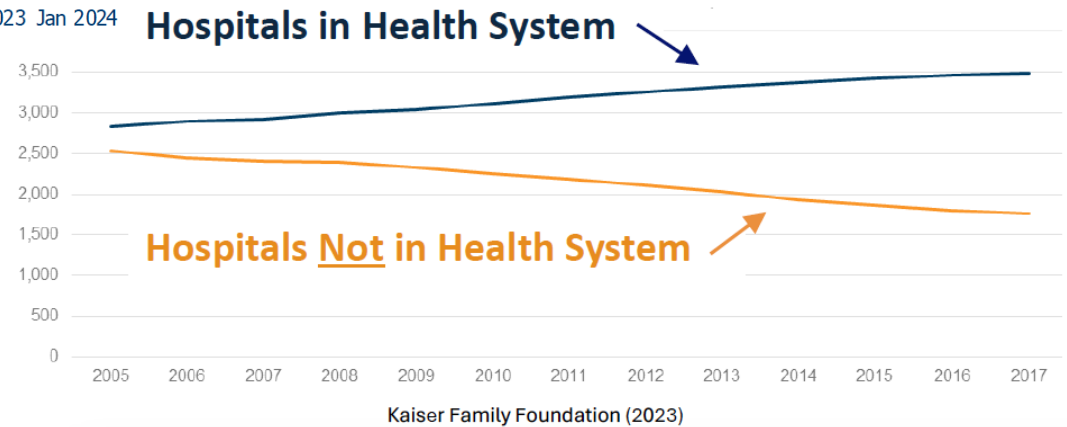
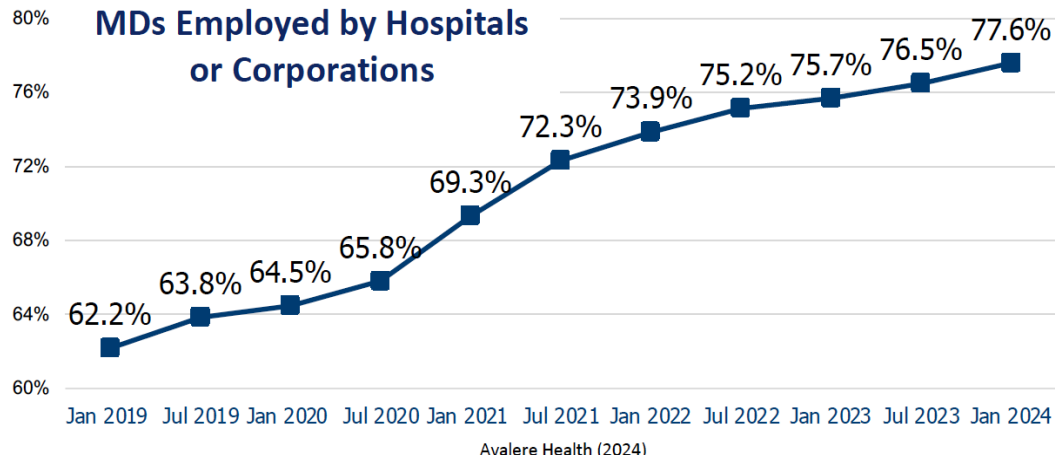
Source: Legal and Regulatory Framework, February 21, 2023 | Manatt, Phelps & Phillips, LLP

## 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	<ul style="list-style-type: none"> <li>• General enforcement limited to licensure actions, compliance orders, prohibiting admissions or requiring patient transfers, other corrective actions, and minor fines</li> <li>• DOH oversees charity care through holding hearings and issuing penalties as needed</li> <li>• DOH is currently evaluating its capacity to engage in meaningful oversight over compliance of these requirements as part of its strategic initiatives</li> </ul>
EOHHS	<ul style="list-style-type: none"> <li>• Enforcement limited to provider enrollment, Medicaid overpayment recovery, and certifying reform initiative participants</li> </ul>
OAG	<ul style="list-style-type: none"> <li>• OAG enforces hospital conversions in partnership with the DOH through approval, approval with conditions, or disapproval of the hospital's application</li> </ul>
OHIC	<ul style="list-style-type: none"> <li>• 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.</li> <li>• OHIC enforces its oversight through issuances of orders, decisions and rulings, or initiating proceedings, hearings, examinations or inquiries.</li> </ul>

# E. National Trend Toward Consolidation & Financialization



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

# E. National Trend Toward Consolidation & Financialization

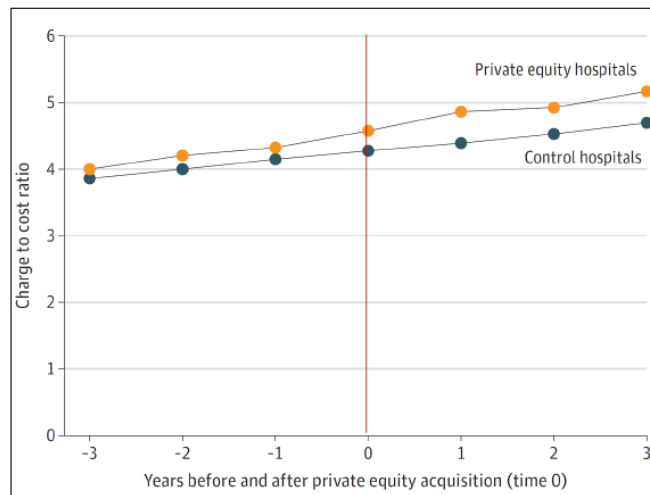


Source: Excerpt from "Consolidation and Financialization in Health Care" presentation by Zirui Song, MD, PhD, Harvard Medical School, Massachusetts General Hospital at NASHP on September 9, 2024

# E. National Trend Toward Consolidation & Financialization

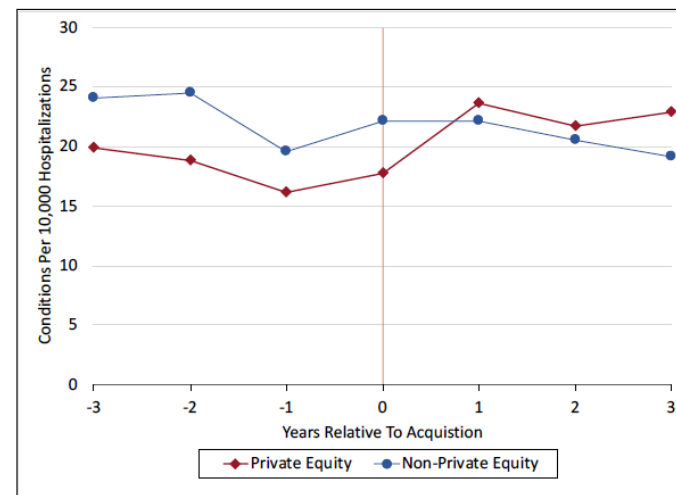
## Impact of Private Equity Acquisitions – Hospitals

**27% ↑ net income, 7-16% ↑ charges  
2% ↓ Medicare patients admitted**



Bruch JD, Gondi S, Song Z. JAMA Intern Med (2020)

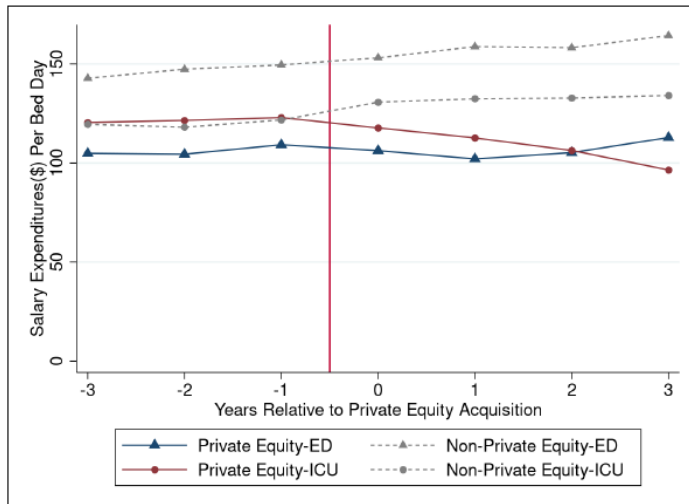
**25% ↑ hospital-acquired adverse events  
(38% ↑ central line infections, 27% ↑ falls)  
12% ↑ transfers to other hospitals**



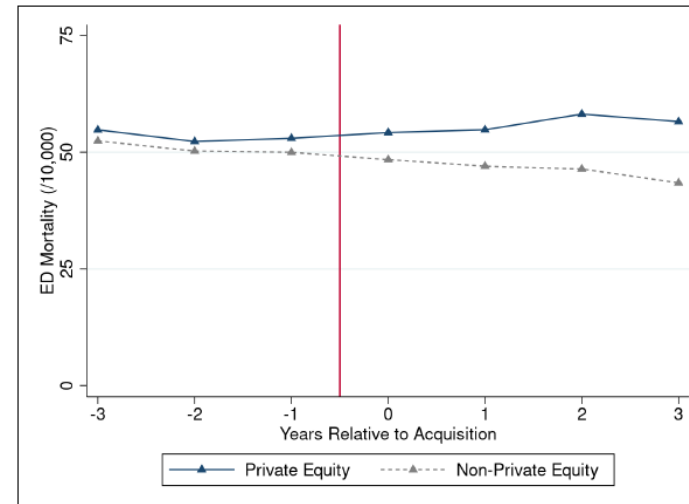
Kannan S, Bruch JD, Song Z. JAMA (2023)

# E. National Trend Toward Consolidation & Financialization

## Impact of Private Equity Acquisitions – Hospitals



**18% ↓ Salary expenditures in the ED**  
**16% ↓ Salary expenditures in the ICU**

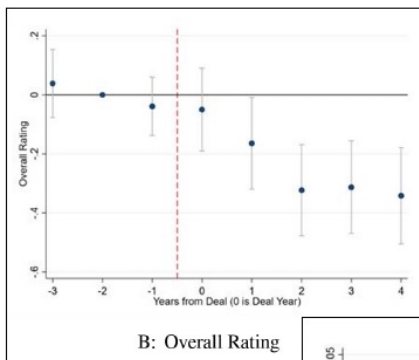


**17% ↑ ED mortality**    **20% ↑ ED transfers**  
**0.2 day ↓ ICU LOS**    **11% ↑ ICU transfers**

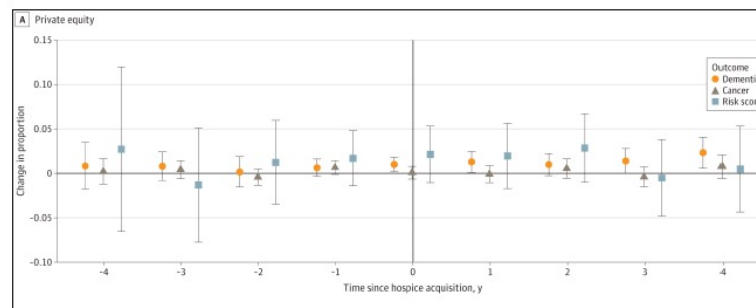
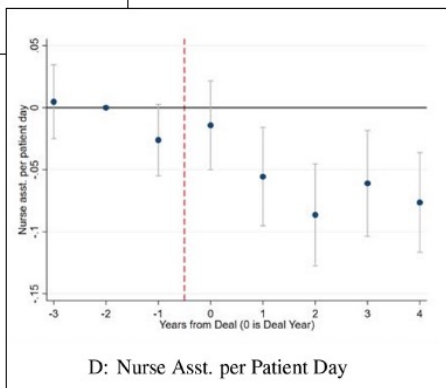
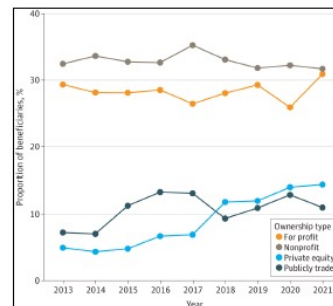
Kannan S, Song Z. Under Review. (2024)

# E. National Trend Toward Consolidation & Financialization

## Impact of Private Equity Acquisitions – Nursing Homes & Hospice



11% ↑ ED visits  
 9% ↑ admits  
 10% ↑ mortality  
 4% ↑ spending



6% ↑ Medicare patients with dementia

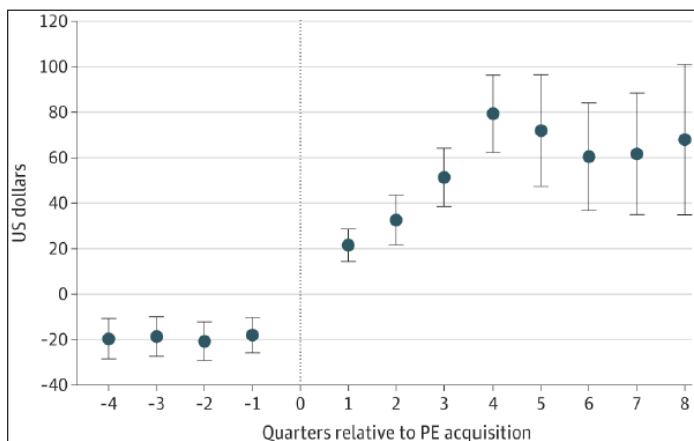
Gupta A, Howell S, Yannelis C, Gupta A. Review of Financial Studies (2023)

Braun RT, Unruh MA, Stevenson DG, et al. JAMA Network Open (2023)

# E. National Trend Toward Consolidation & Financialization

## Impact of Private Equity Acquisitions – Physician Practices

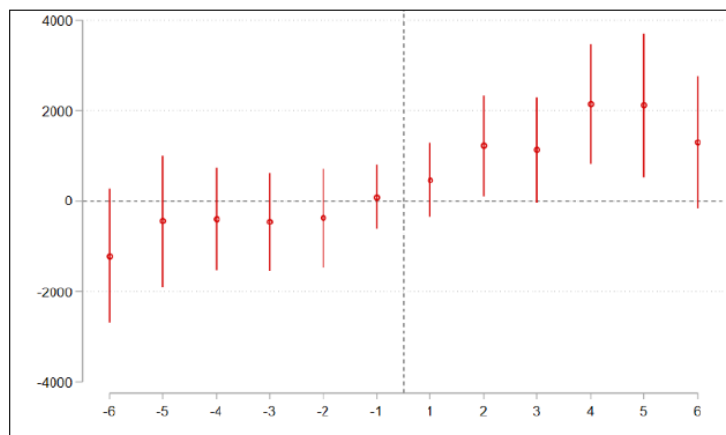
**Dermatology, Gastroenterology, & Ophthalmology**



**20% ↑ charges, 11% ↑ prices  
16% ↑ volume, 9% ↑ long visits**

Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. JAMA Health Forum (2022)

**Ophthalmology**

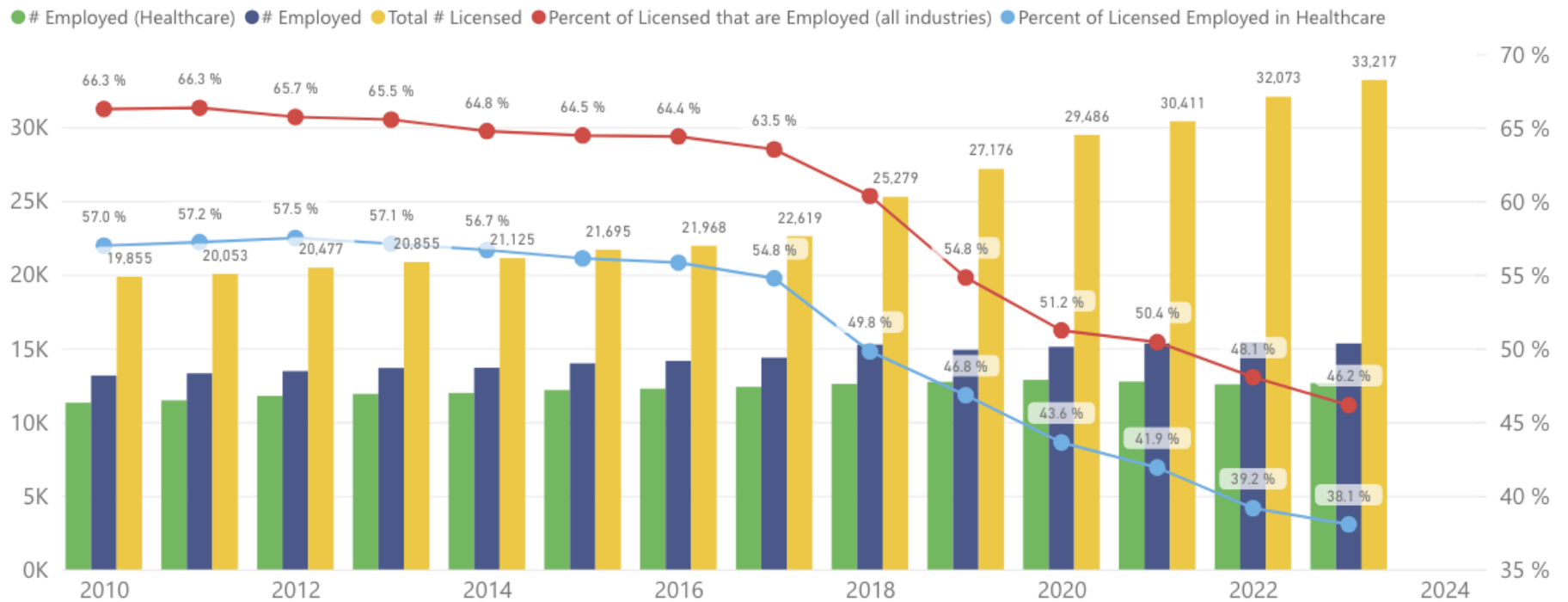


**21% ↑ Medicare spending  
22% ↑ expensive agents**

Singh Y, Aderman CM, Song Z, Polsky D, Zhu JM. Ophthalmology (2024)

# F. 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.



Notes:

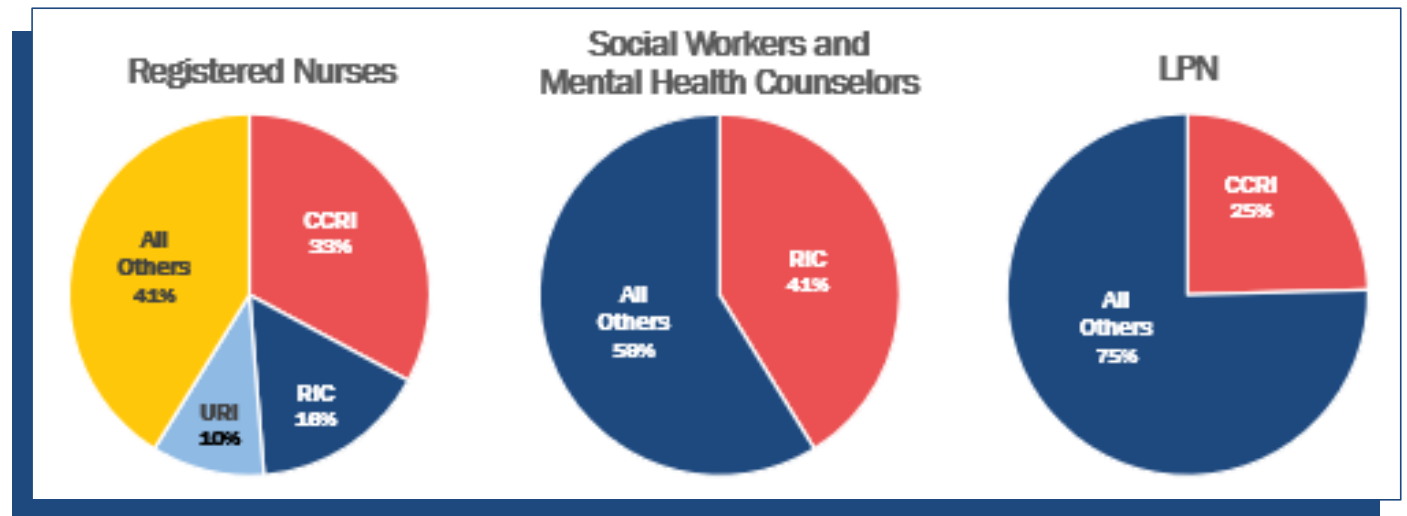
- Partial data for CY2024 is not reported but is available on the RI EOHHS Health Workforce Data Dashboard through July 15, 2024 <https://eohhs.ri.gov/health-workforce-dashboard>
- Beginning in CY2024, we should expect to see significantly fewer total licensed RNs, and a more accurate reflection of the true nursing workforce in RI due to the Nurse Licensure Compact (effective 1/1/24).

## F. Other – Workforce: Rhode Island healthcare relies on public institutions of higher education

Most health professionals working in RI were educated at RI public institutions of higher education.

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Demographics of health professional graduates (not shown here) generally underrepresent the diversity of the State.



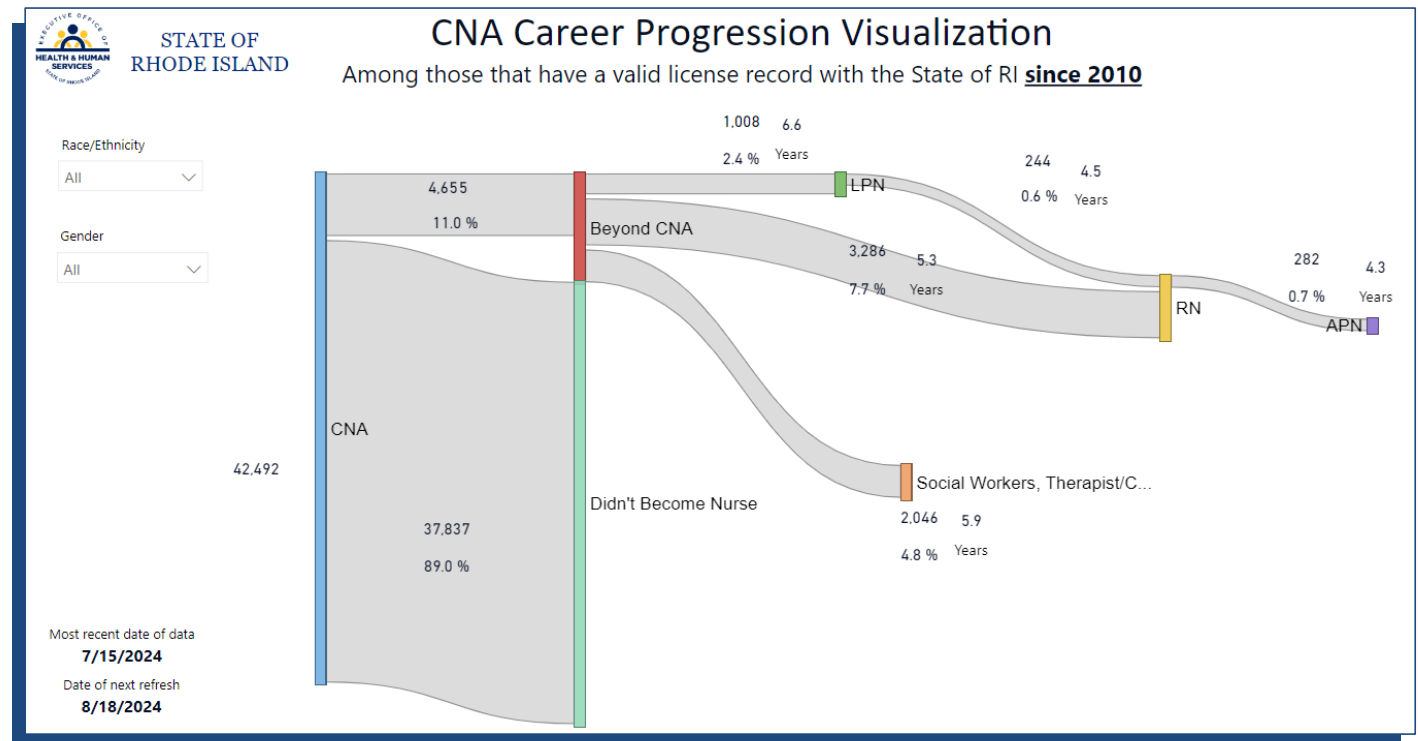
RN, SW, MHC, and LPN employed in RI, by school

# F. Other – Workforce: CNA Career Progression to Nursing

Only 11% of CNAs go on to become an LPN or RN.

Of those CNAs who become RNs, most are White.

But of those RNs who started as CNAs, most are Black and Hispanic.



# and % of Nursing Assistants who have obtained LPN or RN license

## F. Other – Workforce: Draft HCSP Workforce Recommendations

**Pipelines:** Expand and sustain healthcare career awareness and experiential learning opportunities for youth, unemployed and underemployed adults, or other untapped or underrepresented populations

- ★ *Sustain funding for Caring Careers website and social media campaign*
- ★ *Expand partnerships between CTE programs and employers*
- ★ *Sustain funding for Welcome Back Center to support recredentialing and employment of foreign-trained health professionals*

**Pathways:** Expand and sustain academic, financial, and wraparound supports for working adults to pursue healthcare certificates, degrees, and licensure to reduce barriers to success and increase the capacity and diversity of the healthcare workforce

- ★ *Sustain funding for Ladders to Licensure and RI Reconnect*
- ★ *Expand eligibility and scope of RI Promise and Hope Scholarship to include working adults, certificate programs, and Master's level programs*

Draft  
workforce  
recommendations  
for the Health  
Care System  
Planning Cabinet

## F. Other – Workforce: Draft HCSP Workforce Recommendations

**Data:** Expand authority and resources to collect, share, analyze, and report workforce data to inform health system and workforce planning

- ★ *Revise RIDOH health professional licensure forms to address gaps in data collection, per new State statute*
- ★ *Expand DLT wage record data collection to include submission of hourly wages and/or hours worked for all RI-based employees*
- ★ *Enhance capacity to forecast health workforce supply and demand*
- ★ *Integrate all health workforce data functions within EOHHS Policy and Planning, including licensure data, Health Professional Shortage Areas, loan repayment, Health Inventory, and Ecosystem*

**Provider rates & wages:** Analyze impact of recent rate increases to ensure that rates are sufficient to support a diverse, well-trained, stable workforce and ensure access to high quality care and services

- ★ *Determine adequacy of primary care rates relative to other specialties, neighboring states, and population health needs*
- ★ *Tie provider rate increases to employee wage increases by requiring wage passthrough and/or wage transparency*

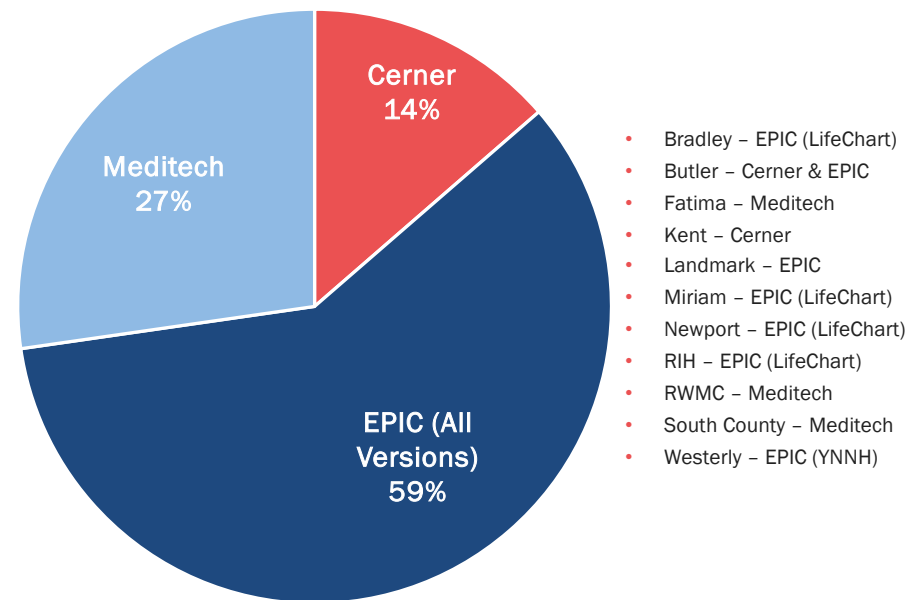
Draft  
workforce  
recommendations  
for the Health  
Care System  
Planning Cabinet

## F. 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**<sup>1</sup>:
  - 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<sup>2</sup>:
  - 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)<sup>3,4</sup>



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

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## Detailed Problem Statements & Draft Solutions

**RHODE  
ISLAND**

# Appendix #1 Materials

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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 & Draft Solutions”

 Yellow box indicates Top 10 priority strategy

# Immediate Action: Repair Strategies

Immediate action is needed to tackle the costs, revenue and infrastructure/investment capacity of Rhode Island's health systems and hospitals

## Immediate Action:

### REPAIR





Excerpts of strategies available here – see Appendix 2 for full detail


## Efficiency/Cost Reduction

-  **Perform initial analysis & build state infrastructure/capacity for ongoing Hospital Fiscal Transparency & Performance Monitoring (with equity lens).** Create initial dashboard of hospital fiscal stability and operational/efficiency metrics. Metrics and analysis to include disparities in health outcomes by race/ethnicity. Implement appropriate data governance for hospitals and health systems. Leverage portion of hospital tax to fund ongoing state infrastructure
- ✓ Define authority and governance model to **support state oversight and monitoring of prior authorizations and denials based on national best practices.** Consider pathways to have these rules apply to Medicare Advantage (e.g., implement participation conditions on Medicaid, DSNP, delegated authority).
- ✓ **Tackle hospital operating costs/efficiency -** Establish pathway & funding for **hospital learning collaborative** on best practices in hospital operations to reduce administrative costs (e.g., billing codes, leveraging HIE, EMRs, centralized back-office infrastructure, etc.)

## Revenue Enhancements

-  Fund/begin a **comprehensive Medicaid rate study** across all physicians and DRGs to inform Medicaid rate decision. **Maintain directed payments/one-time payment mechanisms** to protect hospitals while studies are completed.
-  **Utilize/maximize hospital tax to directly increase Medicaid rates.** Based on results of rate study, comparative to Medicare, other states, transition directed payment, other one-time hospital payment mechanisms into rate adjustments
- ✓ **AHEAD model/Global Budgeting –** Implement AHEAD inclusive of global budgeting. Incorporate additional infrastructure supports for hospitals to support this model.









## Infrastructure Investments

-  **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
- ✓ Build state expertise in cyber security. **Explore Resources through Office of National Coordinator (ONC) for Health Information Technology** for cyber security infrastructure at enhanced match.
- ✓ **Find a funding pathway to clinically (rather than billing) centered EMR investment.** **Potential sources of funds:** Braided federal grant funds, EPIC funds, Brown University.

# Longer-term Action: Redesign Strategies

 Yellow box indicates Top 10 priority strategy


New approaches need to be considered to drive significant transformation at the state, system and hospital levels

| <p><b>Longer-term Action:</b></p> <p><b>REDESIGN</b></p>  <p><i>Excerpts of strategies available here – see Appendix 2 for full detail</i></p> | <p><b>Vision &amp; Data</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <p><b>Regulatory Model</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <p><b>System Design</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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|                                                                                                                                                                                                                                 | <ul style="list-style-type: none"> <li> <b>Establish a vision and plan for RI’s healthcare system, and in particular, the hospital sector</b>, informed by the fiscal status of hospitals and the statewide capacity/needs. Consider RI specific vs regional capacity, hospital vs. alternative structures, health equity and geographic differences. Ensure vision is patient-centered and equity-driven. Consider <b>centralized health system monitoring and oversight</b> - consolidating responsibilities that are currently spread across state agencies to drive strategic healthcare planning.</li> <li> <b>Perform initial analysis of Statewide Capacity &amp; Needs Assessment</b> (to be conducted every 5-10 years). To inform Statewide plan of where/ what acute care services are needed, including bed capacity, prioritizing service capacity for vulnerable communities. Use analysis to inform health system vision, and as a roadmap to infrastructure investment decisions &amp; CON process reforms. Leverage portion of hospital tax to fund this work.</li> </ul> | <ul style="list-style-type: none"> <li> <b>Restructure Oversight of Mergers and Hospital Conversion</b> – Consider expanding the Hospital Conversion Act beyond hospitals to restrict other transition from non-profit to for profit &amp; leverage private equity guardrails in other sectors (physician practices, urgent care) that focus on preventing harms and negative outcomes, so that “returns on investment” don’t detract from patient care. Reduce regulatory barriers to non-profit mergers and out of state alignments – as these restrictions limit critical operational and fiscal improvements. Reduce administrative burden of hospital conversion review process.</li> <li> <b>Reform CON Process: Transform/enhance CON process</b> 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 needed services/infrastructure). <b>Increase \$ threshold</b>, thereby decreasing purchases needing approval, as financial monitoring is increased. Implement, monitor, and enforce <b>conditions on approval</b>.</li> </ul> | <ul style="list-style-type: none"> <li> Based on outcomes of statewide capacity/needs assessment (and fiscal status of hospitals) <b>consider alternative community capacity options for specific geographies</b>. Consider repurposing facilities and staffing at risk hospitals to provide care to local communities through different models, E.g., <b>Consider CMS rural health model, specialty chronic care centers, or Free Standing EDs (FSEDs)</b> –partnered with nearby hospitals and supported with seamless transport/transitions for high acuity patients.</li> <li> <b>Consider a two systems solution - one community-based system</b> focused on chronic condition care with superior primary care, and another <b>focused on acute care needs</b>. Each hospital system has a niche in the market, minimizing unnecessary overlap of service delivery between hospitals.</li> <li> Consider <b>an all-payor standardized rate</b> for hospital services, based on the <a href="#">Maryland model</a>.</li> </ul> |

# Supporting Strategies (1 of 2)

 Yellow box indicates Top 10 priority strategy

Supporting action is required, beyond the scope of hospitals, to address the underlying drivers of hospital & health system fiscal and operational performance.

| Supporting Strategies                                                         | Primary Care & HRSN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Behavioral Health                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Long-term Services & Supports                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| <p>Excerpts of strategies available here – see Appendix 2 for full detail</p> | <ul style="list-style-type: none"> <li> <b>Invest in Primary Care.</b> Hospitals control majority of primary care, but don't have margins to support; could the State take burden off hospitals to support primary care and ensure the funds stays within primary care</li> <li>✓ Move primary care payment to capitation model to allow <b>stable funding to support base operations coupled with incentives to reduce utilization</b> that they can control, like ED utilization.</li> <li>✓ <b>Implement centralized patient navigators for HRSN providers</b> to refer patients with SDOH needs who are returning to hospitals daily – build on HEZ?</li> <li>✓ <b>Rebuild primary care capacity</b>, infrastructure and incentives to create urgent care within practices.</li> <li>✓ <b>Loan forgiveness for PCPs</b> to address shortage</li> <li>✓ <b>Evaluate the role of community health centers</b> given their locations and patients they serve, they can address access from a health equity perspective effectively.</li> <li>✓ Implement <b>AI Scribes</b> to reduce documentation burden for PCPs</li> </ul> | <ul style="list-style-type: none"> <li>✓ <b>Consider additional intermediate care facilities</b>, specifically ICF/IDs to bridge the transition from inpatient to community settings.</li> <li>✓ Open a <b>small stabilization/community discharge unit in Butler</b> – can be interim or partial solution to the lack of step-down options but ultimately need additional ICF capacity.</li> <li>✓ <b>Expansion of BH disciplines within EBPs</b> – seek federal match to invest in innovative BH workforce solutions</li> <li>✓ <b>Maintain/add funding for mobile crises</b> and community based intensive care program and CCBHCs – these are making an impact</li> <li>✓ Create financial incentives for <b>additional BH support/community providers in Northern RI</b> – build on CCBHC requirements?</li> <li>✓ <b>Consider adding another BH-link</b> in the southern part of state</li> </ul> | <ul style="list-style-type: none"> <li>✓ Develop/invest in/ensure regulatory pathways for <b>innovative alternative post-acute care models</b> (e.g., @ 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)</li> <li>✓ Create <b>standardized model for care transitions management</b></li> <li>✓ <b>Retooling of Eleanor Slater Hospital</b> to a true long term acute care hospital (LTACH) with a modernized facility to treat medically complex patients (<i>pending initiative</i>)</li> </ul> |

These cross-cutting strategies must be tackled across sectors/working groups. Preliminary suggestions are included here for discussion.

# Supporting Strategies (2 of 2)



 Yellow box indicates Top 10 priority strategy

Crosscutting workforce strategies, inside and outside the hospital sector are needed to support health system goals

## Supporting Strategies

Excerpts of strategies available here – see Appendix 2 for full detail

## Health Workforce

-  **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.
  - (4) Added workforce investments.
- ✓ **Tie free health professional education (CCRI & other) to in state needs** – require those receiving in state education to work in RI for X yrs.
- ✓ Create pathways (regulatory, payment) for **virtual nursing**
- ✓ Develop **paid nursing apprenticeships** on night shifts for senior nursing students – may need to address credit requirement challenges with accreditors.
- ✓ **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.
-  **Support targeted gaps in hospital workforce**
  - (1) Implement scholarship/incentive-based programs to encourage more diagnostic imaging and medical lab technologists.
  - (2) Establish additional Surgical Technologist Associate Programs in the area – currently only one program at NEIT.
  - (3) Partner hospitals with community-based workforce development providers (e.g., Genesis Center, RI Nurses Institute Middle College) to address these gaps and connect them to untapped community capacity.
- ✓ **Consider requiring entities to enter Labor Peace Agreements to receive Medicaid funding** – allowing unions to fight together/on behalf of hospitals for higher wages.

These cross-cutting strategies must be tackled across sectors/working groups. Preliminary suggestions are included here for discussion.

Note: There will not be time dedicated to reviewing this content during Meeting #2

# Appendix #3

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**Comments for Workgroup Consideration**  
**Source: Hospital Workgroup Priority Solutions Survey**

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# Comments from the Working Group (1 of 4)

In follow up to Meeting #1, HCSP Hospital Sector Working Group participants were asked to complete a survey to vote on priority solutions and to provide additional comments for consideration by the working group. Comments for consideration are included below.

## General Feedback/Guidance on Workgroup Approach

- *“How do we focus on 1-3 things. Less studies.”*
- *“Stay focused - do 2-3 things really well instead of 12-15 not well.”*
- *“Overall, I think the **current recommendations are quite insular and are missing patient- and community-centered perspectives.** Either some of the overarching strategies (such as 1 and 2) should be beefed up with greater community oversight and equity lens more meaningfully integrated (preferable so as not to silo community perspectives or equity), or there should be an additional recommendation around increasing meaningful community oversight, involvement, and accountability. Some (?) hospitals have community advisory councils or boards, but their work is often siloed and buried and not connected to larger regulatory or accountability structures.”*
- *“The list [of strategies] contains disjointed and overly-specific fragments of an approach to identifying and investing in a coordinated continuum of care.”*

## Comments from the Working Group (2 of 4)

In follow up to Meeting #1, HCSP Hospital Sector Working Group participants were asked to complete a survey to vote on priority solutions and to provide additional comments for consideration by the working group. Comments for consideration are included below.

### Reimbursement Rates, Payment Methods & Data

- *“I feel strongly that **the top priority should be to analyze Medicaid rates** and take actions to address the rates. The other goals are far less important but include **analyzing community HC delivery needs** so we can ensure access to the appropriate type of care (e.g., community, ambulatory, tertiary) across the state.”*
- *“I would like to thank the Faulkner team for bringing a lot of complex information together and making the last meeting so productive. I'd also like to share some **hesitance about our subgroup calling primarily for increased State investments into hospital reimbursement rates** (like #17). We are working in a context in which there are also subgroups for primary care, social determinants of health, behavioral health, etc. If we all come back to the main planning group and all call for more investments for "our" sector, I fear that won't be very productive for anyone. I think **the whole system would benefit from more reliable, consistent, and transparent data about rates, financial health of providers, etc.**”*
- *“The state and the providers would be **better served by candid ongoing discussion of the impact of the payment system**. A lot of time was spent on prior authorization, for example, without acknowledging that it is a product of fee for service payment. Too many examples like the preceding to list.”*
- *All of the payment strategies (except for #23 [consider an all-payor standardized rate] perhaps) are more like tactics tinkering around the edges of hospital Medicaid rates. The strategy, if justified by the data, should be to **develop a reimbursement structure that rewards the best performers, however defined, better than the worst performers**. To the extent that is what is intended by the various payment “strategies” it isn't very clear.*

## Comments from the Working Group (3 of 4)

In follow up to Meeting #1, HCSP Hospital Sector Working Group participants were asked to complete a survey to vote on priority solutions and to provide additional comments for consideration by the working group. Comments are included below.

### Transparency, Efficiency & Costs

- “Documenting my support for **hospital fiscal transparency and performance monitoring**...**We need this capacity now. We are flying blind** as a state without comprehensive data on hospital financial performance, revenues, costs, and quality performance. We also need notice requirements and regulatory review of physician group practice acquisitions.”
- “Is there any discussion on **better use of the health information exchange**? This could change discussions on various EMRs etc. If the hospital shared data through the HIE it could also reduce some of the discussion in the issues in #2 Reimbursement/documentation/payment.”
- “I’m not sure where it fits but the **role of specialty providers needs attention**. We focus on primary care and trying to get the most efficiency while there appears to be no like approach to specialty which is significantly more expensive.”
- “There are **opportunities to reduce administrative costs** such as a share utility for back-office functions which I don’t believe was covered in the strategies. Lifespan just implemented reductions in overhead of ~6m. Examining the processes for billing and payment, particularly with automated systems could save significant dollars. I would also suggest a state bond issue to address deferred maintenance to reduce pressure on bottom lines. Obviously, funding would have to come with greater regulatory oversight.”

## Comments from the Working Group (4 of 4)

In follow up to Meeting #1, HCSP Hospital Sector Working Group participants were asked to complete a survey to vote on priority solutions and to provide additional comments for consideration by the working group. Comments for consideration are included below.

### Regulation, Oversight & Approach to Health System Transformation

- “Understanding **oversight/accountability of all hospitals relative to state investment** and importance as a public good would be helpful to prioritization efforts.”
- “There may need to be a **data and evidence-based discussion of regulation vs de-regulation.**”
- “Without data, as to both finances and operations, meaningful planning cannot take place. Also, since I know a little about this subject, I recognize that **there are legitimate complaints about the CON process**, or its outcomes. But, it has been structured by, and the subject of much tinkering by, the general assembly over the nearly 50 years of its existence in its current form. Many of the issues complained of derive from that statutory framework. Moreover, hospitals have generally benefited from its existence. Changes necessary to enhance its effectiveness may not be the solutions sought by those who are most critical of the program. Accordingly, tinkering with **the regulatory apparatus may belong in the longer term arena rather than the short term.**”
- “Echoing my previous comments about the **need for more patient- and community-centered perspectives** before this list of strategies is finalized and makes its way into the final recommendations. I can't emphasize enough how much of a difference truly patient-centered hospital systems can make in a patient's or family's experience of or even perception of effectiveness.”
- “From personal experience, there can also be an **experience of "competition" among hospital networks or providers** that poorly impacts patient experience- this is especially important when, as a small state, not every hospital can offer specialized care in every area. So **it is understandable and even clinically advisable for patients to transfer elsewhere** - even out of state (in our family's case, to Boston Children's) - for care at times. This has to be accepted, acceptable, and planned for”

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 #2

# Appendix #4

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## Broader Cabinet Reference Materials

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ISLAND**

# Appendix #3 Materials

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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. Rhode Island HCSP Initiative **Timeline**
- C. **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

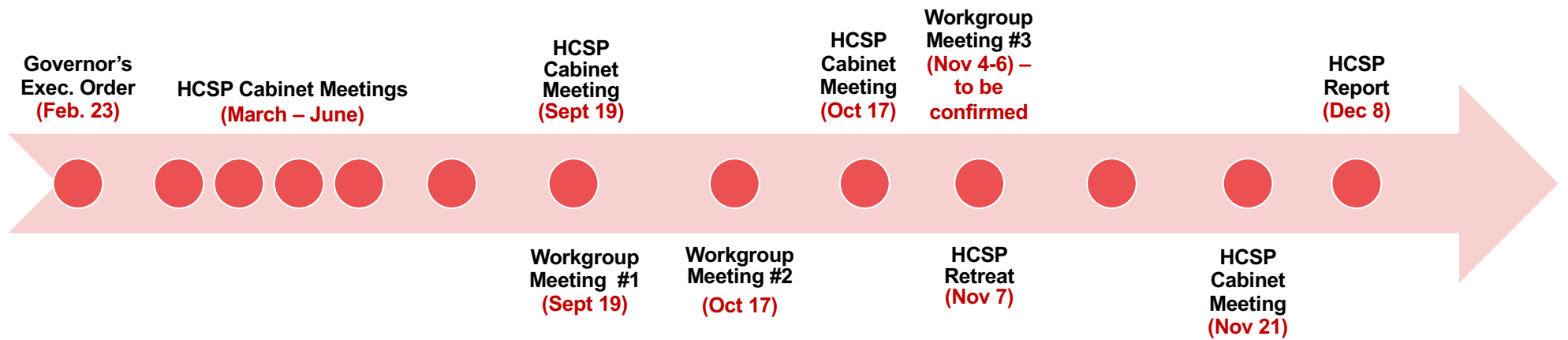
The HCSP will be developed through a comprehensive planning process that:

- 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. Timeline - Rhode Island HCSP Initiative Timeline



## C. 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