EXECUTIVE SUMMARY

REGULATORY AND OVERSIGHT FRAMEWORK GOVERNING RHODE ISLAND HOSPITALS AND PROVIDERS

DECEMBER 2022

The Rhode Island Foundation ("RIF"), in consultation with a group of key industry stakeholders, engaged Manatt, Phelps & Phillips, LLP ("Manatt") to support its efforts to create a regulatory framework in Rhode Island that (i) delivers and supports financially stable, high-performing, locally accountable health care systems by integrating oversight and accountability functions; (ii) eliminates duplication in reporting and oversight; (iii) increases transparency into provider financials and solvency; (iv) creates data-driven accountability; and (v) can be funded and sustained to improve quality, affordability, equity and access to care for Rhode Islanders.

The goal of this initial work is to provide the current state of Rhode Island's legal and regulatory framework across these key domains to inform a broad and inclusive group of stakeholders' engagement on how to further achieve the overarching objectives.

Manatt performed a comprehensive review of the existing laws, regulations, and guidance to identify and compile these requirements that further these objectives. In addition, Manatt consulted with key health care industry stakeholders, which included current and former state officials identified by RIF, to hear their perspectives on how the state regulates and promotes quality, affordability, accessibility, and equity in Rhode Island's health care system.

Short Summary

Rhode Island has the building blocks of a strong regulatory infrastructure; however, Rhode Island, like many other states, has a patchwork of state laws and regulations that address the four domains, with various levels of oversight and enforcement mechanisms available to the regulating state agency and department. The Rhode Island health care system is regulated at its components, usually at the licensed facility level, and in general, no agency or department oversees the entire "system of care."[1] No authority exists for state agencies or departments, either alone or in concert, to regulate entire "systems of care" in a comprehensive and cohesive manner.

The Rhode Island Department of Health ("DOH"), the Office of the Health Insurance Commissioner ("OHIC") under the Department of Business Regulation, the Medicaid Agency under the Executive Office of the Health and Human Services ("EOHHS"), and the Office of the Attorney General ("OAG") each play a role in ensuring the quality, affordability, equity, and access to care for Rhode Islanders, with the DOH having the greatest authority over these domains and playing the most prominent role.

- Most of the requirements pertaining to and oversight of quality of care and access are under the DOH, with the Medicaid Agency playing a role with respect to Medicaid beneficiaries. The OAG plays a significant role when hospitals merge or consolidate.
- Most of the requirements pertaining to and driving affordable care are set forth by and overseen by the OHIC, but much is focused on rate caps for hospitals and ensuring certain spend targets are met by insurers, and only indirectly regulates certain components of the "systems of care".

[1] "System of care" refers to the entire scope of services offered by a common ultimate owner, and, for instance, would include hospitals and any affiliated provider practices, skilled nursing facilities, and home health agencies.

DOH, OHIC, and EOHHS have worked together to create the All-Payer Claims Database, which systematically collects health care claims data from a variety of payer sources, including Medicare, Medicaid, and Rhode Island's nine largest commercial payers. This database was created to ensure transparency of information about the quality, cost, efficiency, and access of Rhode Island's health care delivery system. DOH has enforcement authority over compliance with the data reporting requirements.

This database is utilized to support the Health Spending Accountability and Transparency Program (formerly known as the Healthcare Cost Trends Report), which is a voluntary commitment by many Rhode Island healthcare stakeholders to take reasonable and necessary steps to annually keep cost growth below a set target while at the same time advancing quality and access goals. The Program's activities include publication of insurer and provider performance on cost growth relative to a predetermined health care cost growth target, and annual public meetings on performance relative to the target and actions that are developed in collaboration with health care entities.

Efforts to improve the cohesiveness and comprehensiveness of how Rhode Island regulates and oversees hospitals and providers should take into account the breadth of existing authority granted to agencies and departments, the ways in which such authorities are exercised, and the financial and staffing support necessary for each agency or department to implement and oversee its regulations. Undertaking this inventory and preliminary analysis is a necessary first step to holistically evaluating and forming a plan to modernize Rhode Island's framework for regulating hospital and provider delivery of health care.

Specific Authorities

The Department of Health

DOH, with the advice of the Health Services Council, has authority to promulgate and enforce requirements related to licensure of health care facilities. The licensure standards are intended to ensure proper care and treatment of patients, to promote access to services, and to encourage quality improvement. The DOH also is responsible for licensing individual providers and overseeing compliance with the license requirements.

DOH also has broad authority to enact regulations to promote safe and adequate treatment of patients that are in the interest of public health, safety, and welfare. It has implemented the Health Care Quality Program, under which it collects and utilizes certain quality data from hospitals, other health care facilities, and licensed providers to assess quality of care and provide public information to assist individuals in selecting services. The data collected by DOH from licensed providers is more limited and historically related mostly to their electronic medical record utilization.

While DOH has authority to require the submission of a broad range of data and information, including financial and statistical information related to the financial conditions of health care facilities, which include hospitals, surgery centers, and physician ambulatory-surgery centers, among others, it historically has not requested this information or used it when it received. DOH has recognized the importance of ensuring the financial health of Rhode Island's health care facilities; however, until most recently, it has not had the necessary expertise to perform this analysis in some time. DOH recently engaged a vendor with requisite expertise to perform an analysis of the financial condition of the hospitals in Rhode Island.

DOH is responsible for certificate of need ("CON") reviews through which it evaluates applicants desiring to provide a new service, reduce services or bed capacity, or incur large capital costs or expenditures. In evaluating the CON, the Health Services Council considers a range of factors, including the impact of the CON, if approved or denied, on the cost, access to, and quality of care, as well as the special needs or circumstances of other facilities and providers in Rhode Island.

DOH also has and exercises its authority to evaluate changes in effective control and, together with the OAG, conversions of hospitals based on various criteria, including the impact of a change on both the quality and cost of care provided by the hospital, patients' access to such care, and the hospital's financial stability.

Rhode Island hospitals are responsible for providing adequate levels of charity care and uncompensated care to ensure access to services, which the DOH oversees. Hospitals are required to report on the cost of charity care, bad debt, contracted Medicaid shortfalls, and any other items requested by DOH. Due to limited bandwidth, DOH recognizes that it has not actively overseen hospitals' compliance with these requirements.

To enforce its authority, DOH is authorized to issue compliance orders requiring corrective actions; revoke or suspend hospital licenses; prohibit future admissions or require patient transfers; and impose minor fines for noncompliance or larger fines related to insufficient provision of charity care. In theory, DOH can seek criminal penalties for egregious violations.

The Office of the Health Insurance Commissioner

OHIC, through its broad authority over insurers, indirectly regulates hospitals' and providers' cost of care mainly by imposing cost and quality controls and requirements on insurers, which they then impose downstream on their contracted providers.

OHIC regulates health care affordability by requiring its approval of any increases in insurers' rates for hospital inpatient services above the hospital rate cap. OHIC has not routinely approved increases that exceed the hospital rate cap.

OHIC also requires insurers' hospital contracts to include quality incentive programs and insurer contracts with hospitals and providers to include standardized quality measure reporting mechanisms, data from which must be reported to OHIC by insurers.

OHIC also requires insurers to adopt alternative payment models ("APMs") in a regulatorily defined portion of provider contracts and meet spending targets for primary care and other service lines. OHIC also uses these requirements to drive health care quality, as APMs may be structured to reward high-quality care rather than high-volume care. Furthermore, OHIC oversees provider financial stability if a provider seeks to assume risk from insurers through APMs or other arrangements.

Through regulation, OHIC aims to remove certain barriers to individuals accessing behavioral health by eliminating certain co-payments.

Under OHIC regulation, insurers participating in patient-centered medical home programs must make supplemental payments to providers for care coordination and eliminate behavioral health cost-sharing in certain circumstances.

To enforce its requirements, OHIC can consider insurers' treatment of providers and consumers when issuing orders, decisions on rates or applications, and rulings, or when initiating proceedings, hearings, or examinations in the ordinary course of oversight activities.

The Office of the Attorney General

OAG has expansive authority to regulate hospitals that undergo conversions and to safeguard the quality of care delivered by facilities and providers. A "conversion" is any transfer of 20% or more of ownership, interest or authority in or assets of a hospital pursuant to which a person (and/or their affiliates) holds in the aggregate 20% or more interests in or assets of the hospital. A conversion also means the removal, addition, or substitution of a member or partner that results in a new person gaining a controlling interest in the hospital. OAG reviews the impact of hospital conversions on the affordability of and access to care, and the financial stability of the hospital. This includes evaluations of hospital assets, staffing plans, charity care plans, and community benefits resulting from the conversion.

OAG may enforce its authority by blocking the consummation of hospital conversions, and by investigating and litigating on behalf of consumers, itself, or any state agency.

Outside of conversions, however, OAG does not generally play a role in regulating or overseeing hospitals and providers. While the Healthcare Advocate, an official within OAG, has broad authority to oversee quality and equity in the health care system through investigation of complaints related to the delivery and quality of care, subject to the Attorney General's direction, this oversight authority is solely reactive.

The Executive Office of Health and Human Services

EOHHS has broad authority with respect to the state Medicaid program and related payment reform initiatives but does not have independent authority to regulate hospitals and providers outside the Medicaid program.

EOHHS promotes affordability and quality of care by establishing and implementing payment reform models that incentivize and reward high-quality Medicaid providers in the patient-centered medical home initiative. To inform its initiatives, EOHHS collects data on Medicaid expenditures, outcomes, and utilization rates and reports annually to lawmakers on data trends by provider type, service type, and population served.

One such Medicaid initiative is the accountable entities ("AE") program, through which risk-bearing entities certified by EOHHS hold groups of Medicaid providers accountable for quality, outcomes, and costs of care for an attributed population. EOHHS annually evaluates each AE's finances, operations, and governance during certification, and AEs must notify EOHHS of potential changes in ownership, legal status, or financial stability.

EOHHS enforcement authority is largely limited to making provider enrollment determinations for Medicaid and certifications for related reform initiatives.

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