

# **Report of the Community Hospital Task Force**

Presented to:

Hon. Donald L. Carcieri, Governor, State of Rhode Island  
&  
Hon. Elizabeth H. Roberts, Lt. Governor, State of Rhode Island

**July 27, 2007**

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## Executive Summary

### **Background**

The Community Hospital Task Force was established in April 2007 by Governor Donald Carcieri and Lt. Governor Elizabeth Roberts. They gave the Task Force a 90-day timetable and the charge to examine the current financial health of community hospitals in Rhode Island and make recommendations on systemic changes to help ensure the continued delivery of core services to the communities served.

### **Methods**

The Task Force, whose membership comprised of a broad group of stakeholders, met six times between April 24<sup>th</sup> and July 9<sup>th</sup>. The first four meetings were dedicated to reviewing data and information (all available at [www.ohhs.ri.gov](http://www.ohhs.ri.gov)); the last two meetings consisted of identifying conclusions and prioritizing recommendations for the report. Five focus groups were conducted to gain the perspective of key hospital personnel (CEOs, CFOs, medical and nursing staff leaders, and Board members.) Additionally, the co-chairs of the Task Force (Jane A. Hayward, Secretary of the Executive Office of Health and Human Services, and Dr. David R. Gifford, Director, Department of Health) hosted three Community Meetings at which members of the public provided testimony on the issues facing community hospitals.

The Task Force aimed to identify the common reasons behind the decline in financial health for the group of community hospitals, rather than for any one individual institution, in order to yield recommended solutions that would have a system-wide impact. The Task Force identified eight “community hospitals” (Kent Hospital, Landmark Medical Center, Memorial Hospital, Newport Hospital, Roger Williams Medical Center, St. Joseph’s Health System, South County Hospital, and Westerly Hospital) that do not have either numerous tertiary services or academic programs, and which are not single-specialty hospitals. These community hospitals were the focus of the Task Force’s work.

### **Conclusions**

The Task Force issued this major conclusion on the current financial health of community hospitals:

Unless systemic changes are made, most community hospitals will face continued financial trouble in the coming years. A few hospitals will face more difficulty in the next 2 years, and one community hospital is in dire financial trouble right now.

The key findings supporting this conclusion include the following:

- *Operating margins.* All eight community hospitals had continued negative operating margins in FY2006, following a trend over the past several years of operating losses.
- *Cash flow and net worth.* Despite negative operating margins, most community hospitals have positive cash flow and net worth that has grown modestly since FY2004.
- *Market-related factors.* A decline in the performance of the stock market or pledged donations, which affect hospitals’ endowments, or an increase in pension liability, could create a more immediate financial crisis for several community hospitals.
- *Systemic factors.* There are many factors contributing to community hospitals’ weak financial health. The major systemic challenges that community hospitals face in improving their financial health include:

- *Payment levels and methodology.* The major payers in Rhode Island reimburse hospitals using different methodologies that vary substantially between hospitals for like services. Over half of inpatient services (those not paid by Medicare) are reimbursed by payers using methods that do not reward low-cost, high-quality care. Those same payers reimburse at different levels for like services.
- *Perceived barriers to collaboration and restructuring.* Hospitals perceive challenges in changing the scale and scope of the services they provide by working with other providers, namely other hospitals and community physicians. Some of these challenges are regulatory in nature; others are related to the changing nature of the relationships between hospitals and physicians affected by physician payment issues.
- *Competition for outpatient services.* Consumers have more choices for getting outpatient services in non-hospital settings. Because there seems to be an association between weaker financial performance and greater outpatient activity, the allocation of outpatient services across different entities in the state may be affecting financial health of hospitals.

## **Recommendations**

Task Force members agreed that the reasons behind community hospitals' financial troubles are too complex to be solved with short-term solutions. The only sustainable approach to addressing hospitals' ongoing financial health is to make positive systemic changes. In order to avert an acute crisis in the next several years, steps must be taken now to reach long-term goals for system change.

The Task Force's two main recommendations address the systemic factors that are contributing to community hospitals' weakened financial conditions.

### **1. Reform payment to encourage efficient and high quality care, being mindful of the goal of affordable health care.**

The State should evaluate options for adopting a case-based payment methodology across all payers statewide that encourages efficiency, quality, and collaboration. Any revisions to payment should support ongoing efforts to create an affordable health care system.

#### *Principles*

- Commercial insurers' methodology should be designed consistent with Medicaid and Medicare and implemented with community input, including EOHHS and OHIC involvement.
- The new payment methodology should include pay-for-performance provisions.
- Payment should support primary care infrastructure and realign incentives to remove any reimbursement bias for complex services. Changes in payment should ensure that incentives are sufficient to support low-complexity and preventive services that are effective contributors to health.
- Changes in payment should be used to align financially the interests of hospitals and physicians and thus eliminate some of the competition between them.

#### *Actions*

- Medicaid's payment methodology should be revised by FY2010 or earlier.

- Physician reimbursement levels and methods should be examined in the next several months.

## **2. Encourage collaboration, up to and including mergers.**

State policy and hospitals' management activities should facilitate collaboration across hospitals and between hospitals and other providers. Task Force members identified specific goals for collaboration that would improve community hospitals' financial health, through their ability to reduce costs and improve quality, without leading to increased health care costs overall.

### *Principles*

- A number of options exist for collaboration, ranging from informally sharing best practices to affiliation and merger.
- Through collaboration, hospitals should aim to reduce costs and increase quality, not solely enhance revenue through increased bargaining power. The state's regulatory and reimbursement framework should support this.
- Effective collaboration would address hospitals' stated need to ensure that their own capacity is used most efficiently. For example, this could be achieved by working with other providers so that patients who seek hospital services but would be better served elsewhere can receive the right care in the most appropriate setting.

### *Actions*

- Specific recommendations for 2008 legislative session may include:
  - Evaluate modifying the Hospital Conversions Act.
  - Explore remedies to any barriers to collaboration posed by federal anti-trust laws.
  - Evaluate CON issues related to: a) expanding CON review beyond its current scope; b) the need for and timing of a broad-based moratorium on activities subject to CON review.
- State should conduct health planning to support policy decisions.

## Introduction

On April 10, 2007, Governor Donald L. Carcieri and Lt. Governor Elizabeth H. Roberts announced the creation of the Community Hospital Task Force. The impetus behind the formation of this Task Force was the recognition that many community hospitals have experienced worsening financial difficulties over the past several years. The Task Force was charged with completing its work in 90 days.

The Task Force's charge was to:

Examine the current financial health of community hospitals and recommend system changes that can help ensure the continued delivery of core services to the community.

The Task Force provided a forum in which the hospital system in Rhode Island could be viewed as a whole, while focusing specifically on the challenges facing those community hospitals that are not major tertiary care centers or single-specialty providers. The Task Force aimed to identify the common reasons behind the decline in financial health for the group of community hospitals, rather than for any one individual institution, in order to yield recommended solutions that would have a system-wide impact.

Task Force members recognized that if there were simple solutions that could resolve the financial difficulties of community hospitals, they would have already been implemented. Thus, the Task Force set out to examine the complexity of issues underlying community hospitals' financial health.

## Methods

### *Task Force members*

Jane A. Hayward, Secretary of the Executive Office of Health and Human Services, and Dr. David R. Gifford, Director of the Department of Health, chaired the Community Hospital Task Force. Members included other state government officials as well as representatives from hospitals, insurers, business, healthcare providers, consumers, and members of the legislature (see Attachment 1).

These individuals came from communities all across Rhode Island, and brought experience and leadership from their various sectors. They generously donated their time to attend Task Force meetings as well as to review information and to contribute to Task Force materials between meetings.

### *Task Force meetings*

In order to produce this report, the Task Force convened for six meetings during the months of April, May, June and July. The Governor and Lt. Governor attended the first meeting, and received a summary presentation of the Task Force's findings, conclusions, and recommendations at an additional concluding meeting on July 13, 2007.

A number of meetings were also held to inform the work of the Task Force. The co-chairs of the Task Force hosted three Community Meetings at which members of the public provided

testimony on the issues facing community hospitals. These meetings were well attended, with between 50 and 150 individuals at each. Five focus groups were conducted by staff not affiliated with the Task Force to gain the perspective of key hospital personnel (CEOs, CFOs, medical and nursing staff leaders, and Board members) from all hospitals. The co-chairs reserved 15 minutes of every Task Force meeting for public comment as well. A list of all related meetings is available in Attachment 2.

### *Information reviewed*

The members of the Task Force had varied levels of experience and knowledge in the specific topics under discussion at the Task Force meetings. In order to assure that Task Force members had the same set of facts with which to examine the financial conditions of hospitals and make recommended system changes, the Task Force co-chairs responded to many requests for information from Task Force members by introducing a number of written sources before the Task Force.

These sources are posted on the Executive Office of Health & Human Services website: <http://www.eohhs.ri.gov/taskforce/index.php>. Each source contributed to the evidence on which the findings and recommendations are based (see annotated source list, Attachment 3). The sources fall into the following categories:

1. **Published reports.** The Rhode Island Department of Health and other state and federal entities make reports available on hospital finances, hospital payment methodologies, and hospital financial analysis. Some of these reports pertained specifically to hospitals in Rhode Island, while others provide information about the context in which hospitals operate nationwide.
2. **Unpublished ad hoc reports and analysis produced by Rhode Island state agencies specifically for the Task Force.** These materials are the products of staff work in response to requests from the Task Force for additional information pertaining to hospitals in Rhode Island, including their current financial situation and other characteristics. Some of these reports provide information for the eight community hospitals that are the focus of the Task Force (see “Definitions,” below); some reports include information on additional general acute care hospitals or specialty hospitals. Some provide descriptions of policies or programs that relate to hospitals in this state.
3. **Presentation on drivers of financial performance produced by independent consultants (see Source #37, Attachment 3).** In response to a suggestion from Task Force members in the first meeting, the co-chairs of the Task Force engaged a team of consultants to conduct a financial analysis of hospitals in Rhode Island and identify some of the drivers of financial performance. The consultants, Nancy and Michael Kane, used a methodology that grouped hospitals according to their financial strength (stronger, middle, weaker) using traditional financial ratios and the most recent cumulative four year cash flows determined from standardized, audited financial statements. These groupings made it possible to evaluate possible drivers of financial strength. In order to make three meaningful groupings for comparison, the consultants included ten general acute care hospitals in Rhode Island in their analysis – the eight community hospitals (see Definitions, below) plus Rhode Island Hospital and The Miriam Hospital. The hospitals could be categorized into three groups based on their consistent performance on each of the following factors:
  - Operating margin

- Debt service coverage
- Four year cumulative operating income/loss
- Equity financing ratio
- Four year cumulative capital spending relative to cumulative depreciation expense
- Four year cumulative issue/repayment of long-term debt
- Four year cumulative change in Board-designated investment and short-term cash and investments
- Days cash on hand including Board-designated investments
- Four year cumulative change in the amount reserved for settlement with third party payers

### *Definitions*

For the purpose of analyzing the challenges and solutions for community hospitals in Rhode Island, the Task Force identified hospitals in Rhode Island in these groups:

1. The eight community hospitals that are the focus of the Task Force are:
  - i. Kent Hospital
  - ii. Landmark Medical Center
  - iii. Memorial Hospital of Rhode Island
  - iv. Newport Hospital
  - v. Roger Williams Medical Center
  - vi. South County Hospital
  - vii. St. Joseph Health Services – Our Lady of Fatima Hospital
  - viii. Westerly Hospital
  
2. Additional hospitals in Rhode Island that are tertiary hospitals or single-specialty hospitals that also play an important role in the community include:
  - ix. Bradley Hospital
  - x. Butler Hospital
  - xi. Eleanor Slater Hospital (state hospital)
  - xii. The Miriam Hospital
  - xiii. Rhode Island Hospital
  - xiv. The Rehabilitation Hospital of RI
  - xv. Women and Infants' Hospital

### Findings and Conclusions

The Task Force reviewed a number of sources of data and information in order to understand the complexity of issues facing community hospitals and the health care system in Rhode Island. Based on this examination of the evidence and the identification of key findings, the Task Force developed several conclusions that are categorized under the following two headings:

- I. Financial health of community hospitals
- II. Systemic factors contributing to financial health of hospitals

In this section, each conclusion introduces the set of key findings that supported it. The Task Force identified additional findings that did not pertain to the major conclusions that the Task

Force drew from the body of evidence as a whole. Those findings are not included here, but are available in a preliminary findings document (see Source #43, Attachment 3).

## I. Financial health of community hospitals

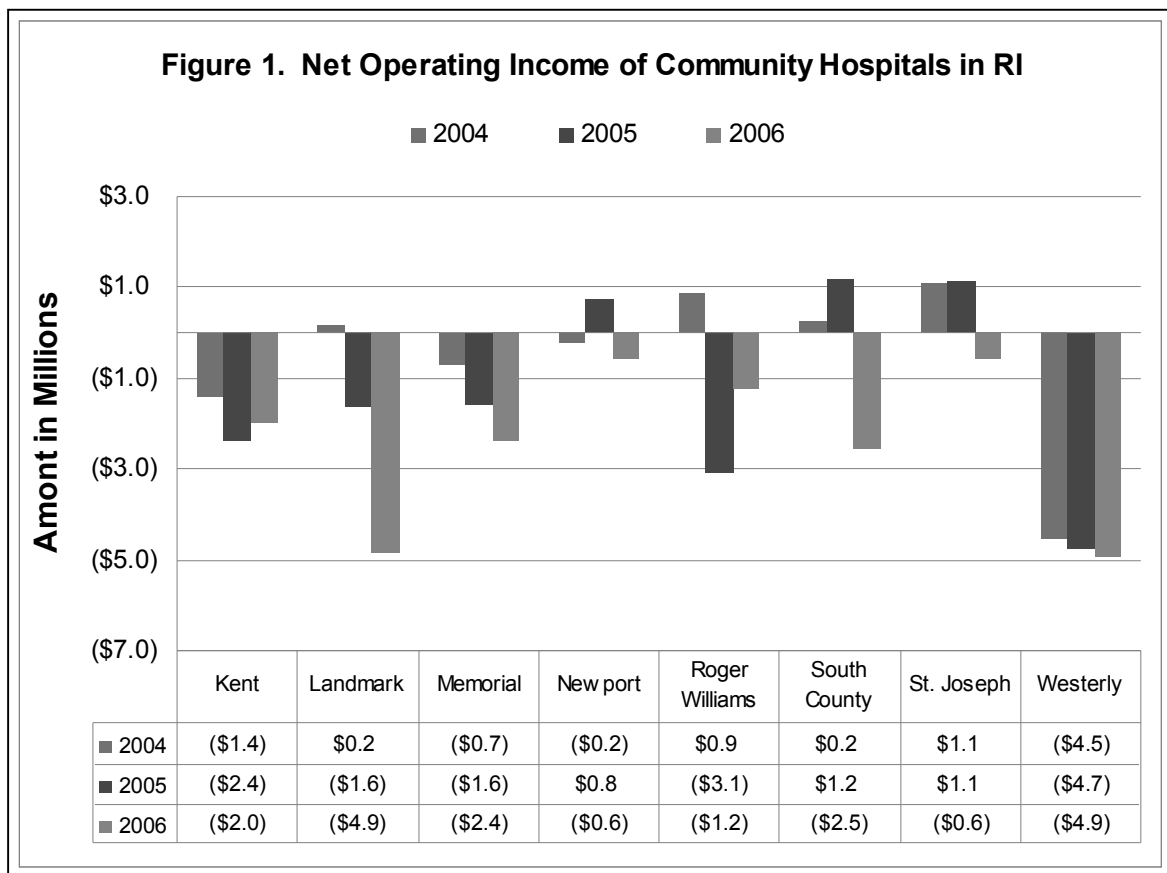
### Conclusion

Unless systemic changes are made, most community hospitals will face continued financial trouble in the coming years. A few hospitals will face more difficulty in the next 2 years, and one community hospital is in dire financial trouble right now.

### Key findings – Financial health of community hospitals

A number of findings contributed to the Task Force’s conclusion that community hospitals are in weakened financial condition, but that there is not yet an acute fiscal crisis system-wide.

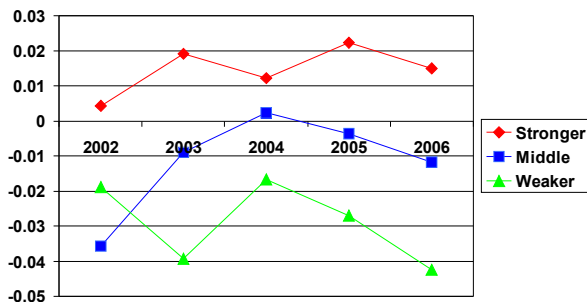
- As shown in Figure 1, hospitals’ net operating income has been declining in the past several years. Data from the first two quarters of fiscal year 2007 (not shown) suggest that the trend of operating losses is continuing, and will worsen substantially if hospitals make no changes in operations.



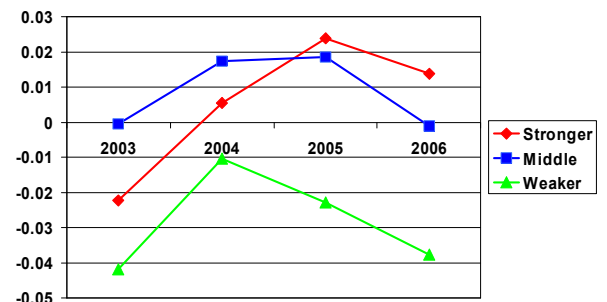
- As shown in Figures 2 and 3, after adjusting for the amount hospitals reserve for anticipated collections from third party payers, overall operating margins are more positive than negative. There is variation in how hospitals recognize operating revenue from third party

payers in a given fiscal year. Because the settlement process with third party payers takes 2-3 years after the service is rendered, hospitals reserve dollars in order to ensure that they have sufficient funds to reconcile estimated payments and actual payments. Operating margins can be adjusted by looking at the difference in the amount that hospitals generally set aside to reserve against potential third party payer settlement liabilities and the amount that is eventually counted as revenue. Increasing the amount set aside for this reconciliation process decreases hospitals' operating margins. Because operating margins are affected by the variation in estimating the amount needed to reserve against anticipated third party settlements, this analysis adjusts for that variation and is an additional piece of information when interpreting information on operating margins.

**Figure 2. Average Operating Margins**



**Figure 3. Average Operating Margin Adjusted for Third Party Reserve Changes**



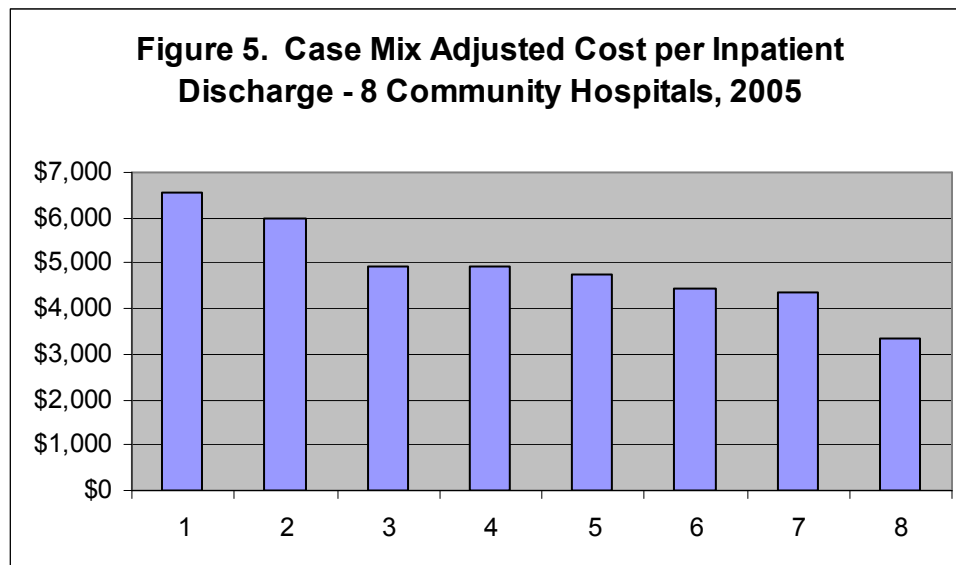
- Operating margin is not the only factor to consider when assessing hospitals' financial health. Most community hospitals have experienced positive cash flow in recent years. Some community hospitals' net worth that has grown modestly since FY2004 (see Figure 4). This growth includes increases in endowment funds due to current market performance. An unexpected decline in the performance of the stock market or pledged donations, which affects hospitals' endowments, or a change in pension liability, could create a more immediate financial crisis for several hospitals. Several Task Force members noted that even though most hospitals have a positive net worth, all the resources that contribute to increasing net worth are unknown and therefore should not be counted upon to resolve hospitals' financial difficulties.

<b>Figure 4: Net Worth (Net Assets)</b>			
<i>amounts in millions (\$000,000s)</i>	<b>2004</b>	<b>2005</b>	<b>2006</b>
<b>Kent</b>	\$79.4	\$79.2	\$82.8
<b>Landmark</b>	\$0.6	(\$0.5)	(\$2.4)
<b>Memorial</b>	\$76.8	\$75.2	\$79.9
<b>Newport</b>	\$223.8	\$249.5	\$267.8
<b>Roger Williams</b>	\$35.6	\$40.4	\$38.4
<b>South County</b>	\$52.0	\$56.0	\$61.2
<b>St. Joseph</b>	\$44.5	\$46.2	\$44.6
<b>Westerly</b>	\$52.5	\$50.2	\$50.5

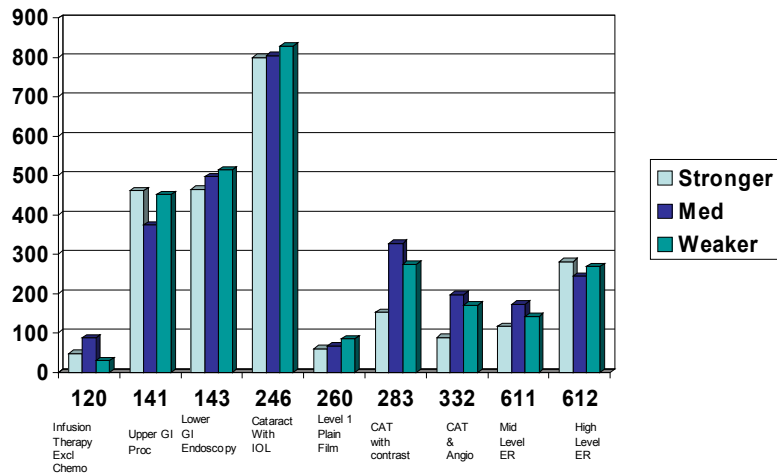
- There is variation in the financial strength of hospitals within Rhode Island. For example, hospitals with stronger financial performance consistently demonstrated favorable positions on each of these measures of financial performance:
  - Operating margin
  - Operating margin adjusted for third-party reserve changes
  - Total margin
  - Days cash on hand
  - Equity financing ratio
  - Debt service coverage ratio
  - Ratio of capital expenditures to depreciation expense

*Key findings – Hospital costs*

- There is variation across community hospitals in the average costs per inpatient (see Figure 5) and per outpatient service (see Figure 6) provided.

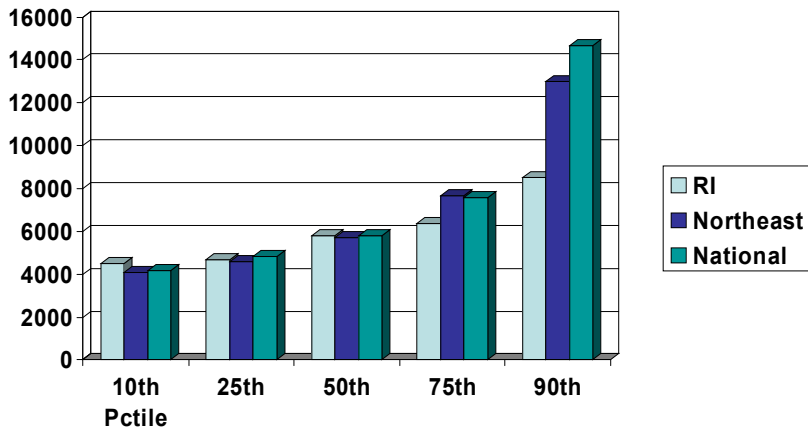


**Figure 6. Average Unit Costs, Nine Common Outpatient Procedures**



- In Rhode Island, the median hospital's cost per inpatient (across *all* Rhode Island hospitals) is approximately equal to the median hospital's cost nationally and in the Northeast (see Figure 7).

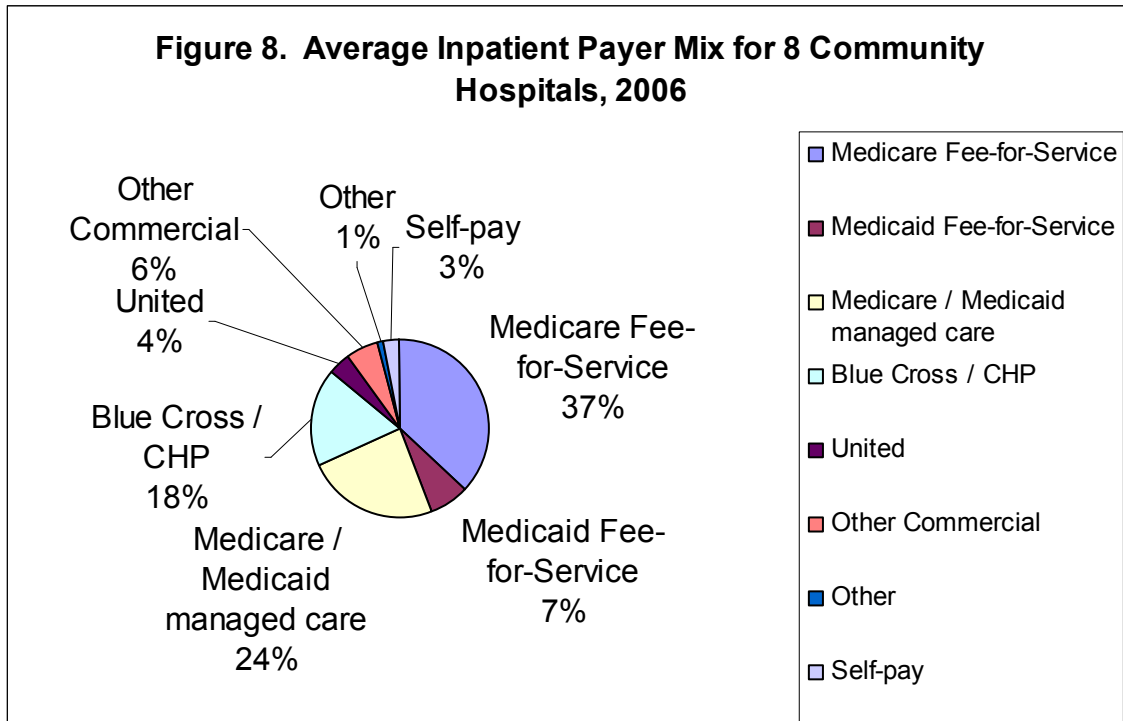
**Figure 7. Hospital Cost per Case, Adjusted for Case Mix Index and Wage Index, 2005**



Source: Ingenix Almanac of Hospital Financial and Operating Indicators, 2007 Using the Medicare Cost Report Indicators

*Key findings – Medicare*

- There is some variation across hospitals in the relative proportion of inpatient discharges that are reimbursed by various payers, but very little variation over time within the same hospital. Medicare is the largest source of reimbursement to hospitals for inpatient services relative to other sources (Figure 8).



- The average margin on Medicare fee-for-service reimbursement to hospitals nationally varies by type of hospital. The margin has been negative for urban hospitals and for nonteaching hospitals in the past several years. See Figure 9, excerpted from MedPAC document “Hospital inpatient and outpatient services.” Report to Congress, March 2007. Page 60. Available at: [www.medpac.gov](http://www.medpac.gov).

**Figure 9.****Overall Medicare margin by hospital group**

Hospital group	2002	2003	2004	2005
All hospitals	2.4%	-1.4%	-3.1%	-3.3%
Urban	3.0	-1.0	-3.0	-3.3
Rural	-2.2	-4.2	-3.8	-3.0
Major teaching	11.4	6.4	4.8	4.2
Other teaching	1.6	-1.8	-3.6	-3.9
Nonteaching	-2.1	-5.5	-7.2	-6.9

Note: Data are for all hospitals covered by the Medicare acute inpatient prospective payment system in 2005. A margin is calculated as payments minus costs, divided by payments; margins are based on Medicare-allowable costs. Overall Medicare margin covers acute inpatient, outpatient, hospital-based home health and skilled nursing facility (including swing bed), inpatient psychiatric and rehabilitation services, and graduate medical education.

Source: MedPAC analysis of Medicare cost report data, MedPAR, and impact file from CMS.

### *Key findings – Drivers of financial performance*

- The following characteristics were associated with stronger financial performance among general acute care hospitals in Rhode Island. See source #37 in Attachment 3 for more documentation:
  - Higher inpatient occupancy rates
  - Greater number of beds
  - Fewer Medicare patients
  - Greater numbers of Medicaid patients and uninsured patients
  - Lower cost per outpatient case for several of the highest-volume outpatient procedures
  - Higher amount of free care
  - Lower amount of bad debt
  - Larger teaching programs.

## **II. Systemic factors contributing to financial health of hospitals**

While there are many factors contributing to community hospitals' weak financial health. The Task Force concluded that there are two major systemic challenges that community hospitals face in improving their financial health.

### **A. Variation in payment levels and methodology**

#### *Conclusion*

The major payers in Rhode Island reimburse hospitals using different methodologies that vary substantially between hospitals for like services. Over half of inpatient services (those not paid by Medicare) are reimbursed by payers using methods that do not reward low-cost, high-quality care. Those same payers reimburse at different levels for like services. This is a systemic factor that influences hospitals' financial health.

*Key findings – hospital payment*

- There is variation in the method by which hospitals are paid for similar services, depending on payer. See Figure 10.

**Figure 10. Payment methods used by major payers in Rhode Island.**

<i>Payment method</i>	BCBSRI	United	Medicaid	Medicare
Per diem	X	X		
Case rate		X		X
% of charges			X	
P4P	●			●

X = Current method  
● = Initiating method

- Different methods of payment provide different financial incentives for hospitals and payers. See Figure 11. The Task Force did not review any data that describes how hospitals manage the conflicting incentives offered by the different methodologies.

**Figure 11. Hospital reimbursement methodologies**

Method	Description	Incentive to hospitals
Per Diem	Hospital is reimbursed for each day the patient remains in the hospital. The daily rate may vary by service type, and can be all-inclusive or have various costly equipment or supplies excluded and reimbursed on a cost basis.	<ul style="list-style-type: none"> <li>➤ Extend length of stay (LOS)</li> <li>➤ Lower daily costs</li> <li>➤ Negotiate for highest per diem rates</li> </ul>
Case rate (based on Diagnosis Related Groups, or DRGs)	Hospitals receive a single payment for a patient's entire hospital stay that varies according to the reason for the hospital stay, categorized by Diagnostic Related Groups (e.g. pneumonia, hip surgery, diabetes, etc). There may or may not be adjustments for different levels of complexity within each group or for outlier cases that have very long or complex stays.	<ul style="list-style-type: none"> <li>➤ Minimize LOS</li> <li>➤ Increase volume</li> <li>➤ Increase efficiency</li> <li>➤ Assure patients are categorized into the most optimally-reimbursed DRG based on condition</li> <li>➤ Admit low-complexity cases</li> </ul>
Charges or Percent of Charges	Each hospital is reimbursed for what they charge for each service (often much more than what insurance pays under DRG or Per Diem) or a percentage of that amount. Individuals without insurance are often billed the hospitals' charges. Hospitals providing care to patients	<ul style="list-style-type: none"> <li>➤ Increase charges</li> <li>➤ Increase LOS</li> </ul>

	who are “out of network” may bill the patient their charges.	
Pay-for-Performance (P4P)	Reimbursement is based on achieving desired outcomes or performance targets. Note: The lack of performance measures and small numbers of patients related to each outcome has limited the use of this method to only areas with measures and adequate number of patients.	<ul style="list-style-type: none"> <li>➤ Implement evidence-based practices associated with outcome</li> <li>➤ Provide services in most efficient manner to achieve outcome (e.g. decrease LOS and amount of services)</li> </ul>

- There is variation in the average inpatient reimbursement that the eight community hospitals receive from each payer. See Figure 12. Some of this variation may be related to the varying reimbursement that hospitals receive from different payers for the outpatient services that they provide. Commercial insurers point out that reimbursement methods and levels are negotiated together for the comprehensive set of services provided by the hospital.

**Figure 12. Variation in average reimbursement from each payer for 8 community hospitals**

% difference from referent hospital <sup>1</sup>	# Community Hospitals			
	BCBS	United	Medicaid	Medicare <sup>2</sup>
100 to 120%	6	5	1	7
121 to 140%	1	0	3	1
141 to 160%	1	3	1	
>161%			3	

<sup>1</sup> Comparing each hospitals average per diem reimbursement to the lowest reimbursed hospital by each insurer.

<sup>2</sup> Average Medicare case rate rather than per diem rate, since Medicare reimburses on case basis. Medicare reimbursement is based on the following formula: (Base rate) X (wage index) X (Diagnosis Related Group weight). All hospitals in Rhode Island have the same base rate and wage index.

## B. Perceived barriers to collaboration and restructuring

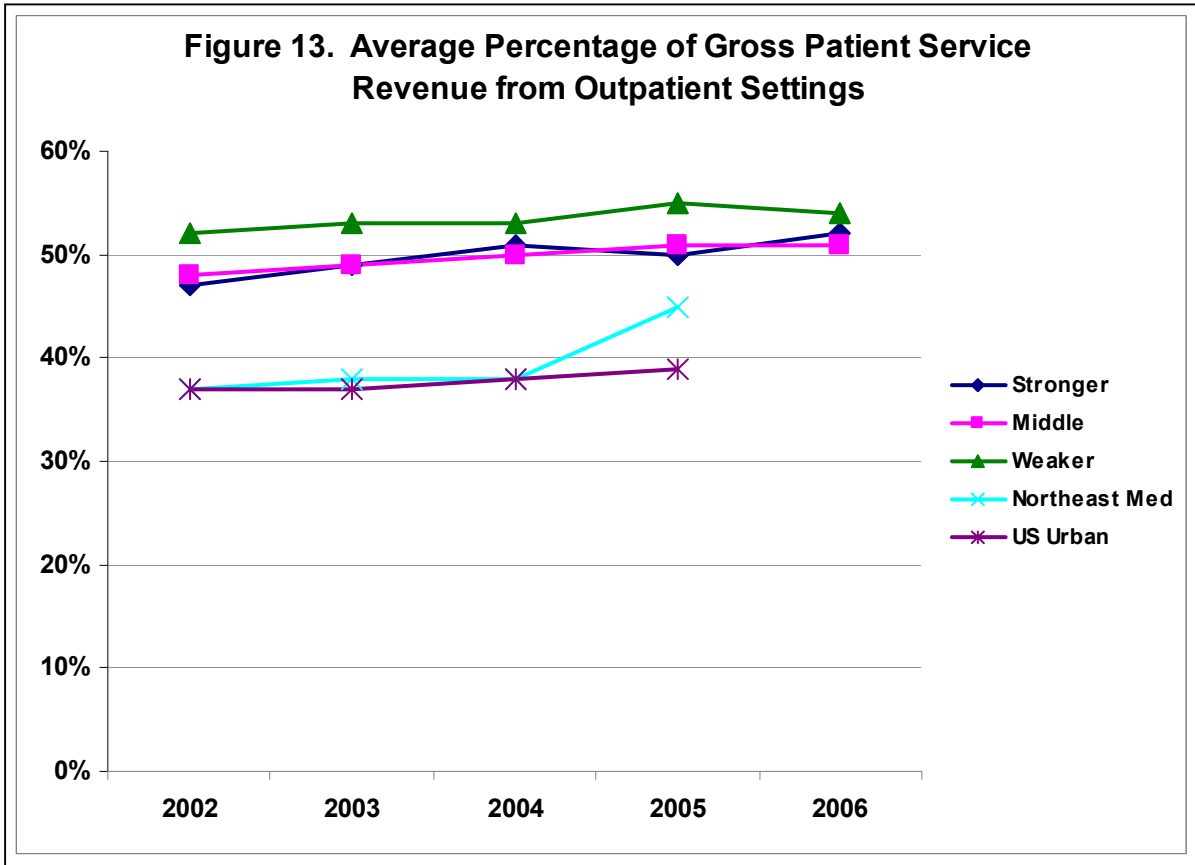
### Conclusion

The regulatory and reimbursement framework in which hospitals operate currently creates perceived barriers to facilitating collaboration and restructuring between hospitals and between hospitals and other providers. Another factor is the willingness of hospitals to collaborate under the current environment oriented towards competition. This is a systemic challenge that faces community hospitals and influences their financial health, specifically because the scale and scope of hospital services affects hospitals’ performance.

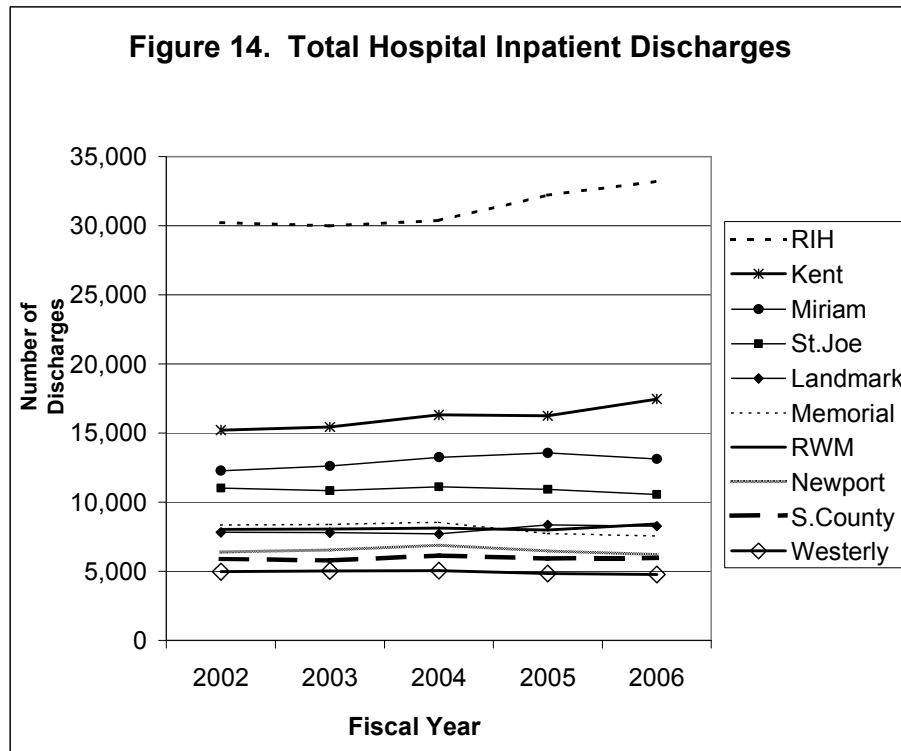
### Key findings – Volume of services

- The level of outpatient services provided by hospitals in Rhode Island is high as a percentage of total hospital activity as compared with hospitals regionally and nationally. Additionally, when grouped by strength of financial performance, hospitals with weaker

financial performance have the highest proportion of outpatient activity as measured by revenue. See Figure 13.



- Inpatient volume is increasing or remaining constant across most general acute care hospitals in RI. The variation in community hospitals' size (number of staffed beds per community hospital range from 70 – 320; Rhode Island Hospital has 609 staffed beds) contributes to the variation in total discharges across hospitals. See Figure 14.



*Key findings - Regulations*

- Hospital Conversions Act (HCA). There have been no changes in ownership or control of hospitals (by for-profits or non-profits) in Rhode Island that have been processed through the Hospitals Conversions Act (Rhode Island General Laws, Chapter 23-17.14) since its passage in 1997. Only two applications were filed under the HCA, both by non-profit entities, but never reached the stage of formal review and were instead withdrawn. Some Task Force members raised issues regarding the review process under the HCA. More information is needed about the aspects of the HCA process that were a factor in the withdrawal of applications that have been filed by non-profit entities under the HCA, or the perceptions of barriers that the HCA presents to collaborations, affiliations, and mergers.
- Certificate of Need (CON) review. There is a universal CON review requirement for the acquisition of medical equipment with costs in excess of \$1 million and for the initiation or expansion of tertiary services, regardless of health care facility type or health care provider type. Additionally, hospitals, nursing facilities, freestanding ambulatory surgical centers and facilities providing inpatient hospice care are subject to CON requirements for construction, expanded capacity, capital expenditure for equipment or capacity meeting certain thresholds, while other health care facilities or providers (e.g., physicians, physician office operatories, ambulatory care facilities) are not subject to review.
- Health planning. Although authorized in statute, there is presently no Rhode Island State Health Plan nor specific public need standards within the regulations regarding Certificate of Need (CON). CON regulations contain broad criteria to review the need

for new health care facilities, services, and medical equipment. CON applications are reviewed on a case-by-case basis utilizing broad review criteria and not within the context of an adopted state health plan with specific community need standards.

*Key findings – Physician payment issues*

- While the Task Force did not evaluate data supporting the following assertions, the Task Force members generally accept that physicians in Rhode Island have overall lower reimbursement (for inpatient and outpatient services) than in Massachusetts or Connecticut. This has two main effects: 1) It adversely affects hospitals' ability to recruit and retain physicians in Rhode Island, and 2) It provides incentives to physicians to provide outpatient services in those states rather than in Rhode Island, which increases competition for those outpatient services that hospitals often provide.

### **C. Uncompensated care**

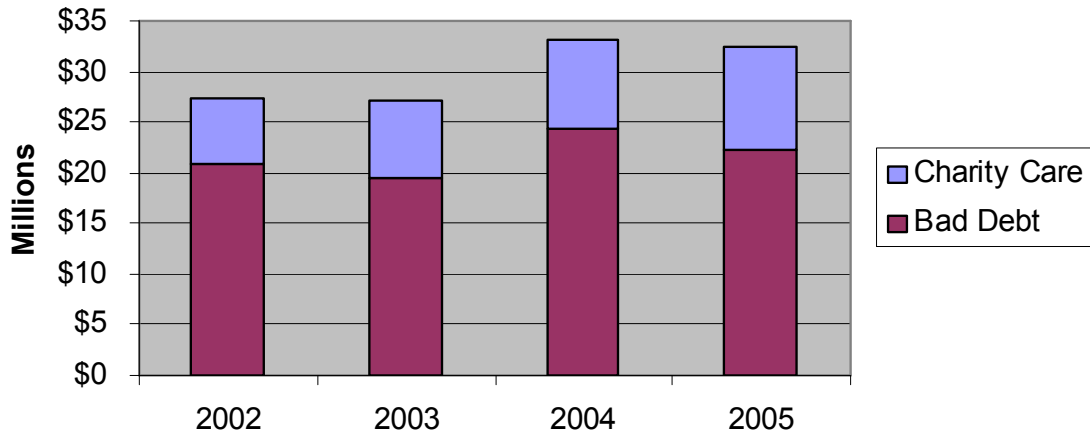
*Conclusion*

On the basis of the key findings presented below, the Task Force concluded that bad debt related to commercial insurance products was not a systemic factor influencing hospitals' financial health, and therefore did not prioritize any recommended next steps related to bad debt.

*Key findings – Uncompensated care*

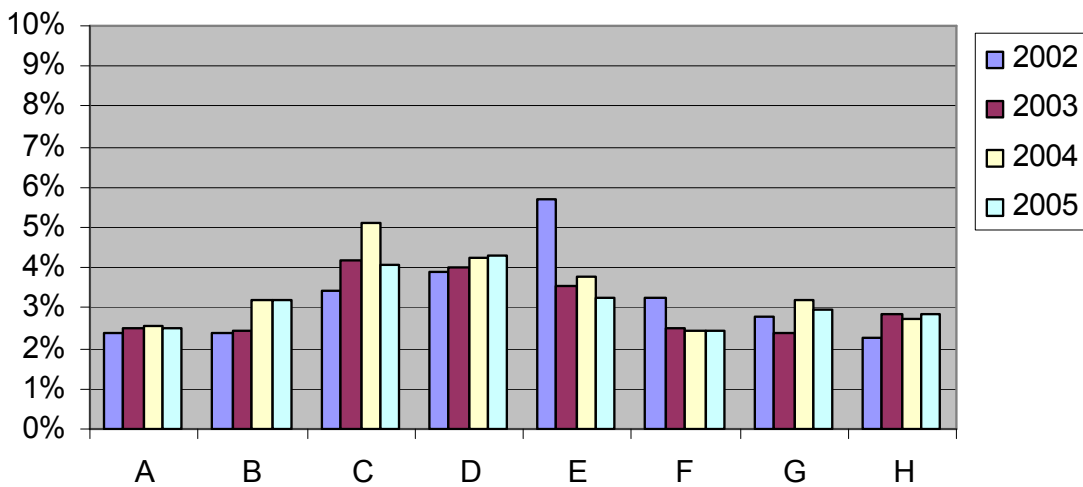
- Uncompensated care is care that hospitals have provided but for which they did not receive reimbursement. Uncompensated care includes two major components:
  - **Charity (free) care:** The value of care delivered to individuals without insurance who are not expected to pay for services due to their poor financial status.
  - **Bad Debt:** The value of care that remains uncollected for services in the inpatient and outpatient settings that have been delivered and billed by hospitals.
- About 75% of uncompensated care experienced by the 8 community hospitals is due to bad debt; 25% due to free care. See Figure 15.

**Figure 15. Percentage of uncompensated care due to bad debt and to free care, adjusted by the cost-to-charges ratio for each community hospital**

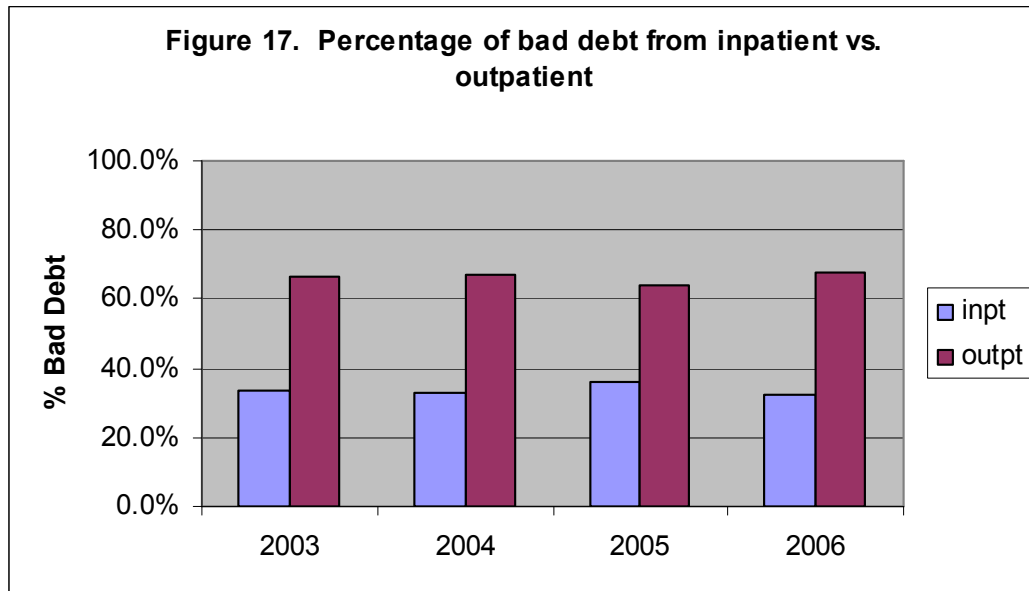


- Uncompensated care as a proportion of patient revenue has remained most constant or has increased for the 8 community hospitals. See Figure 16.

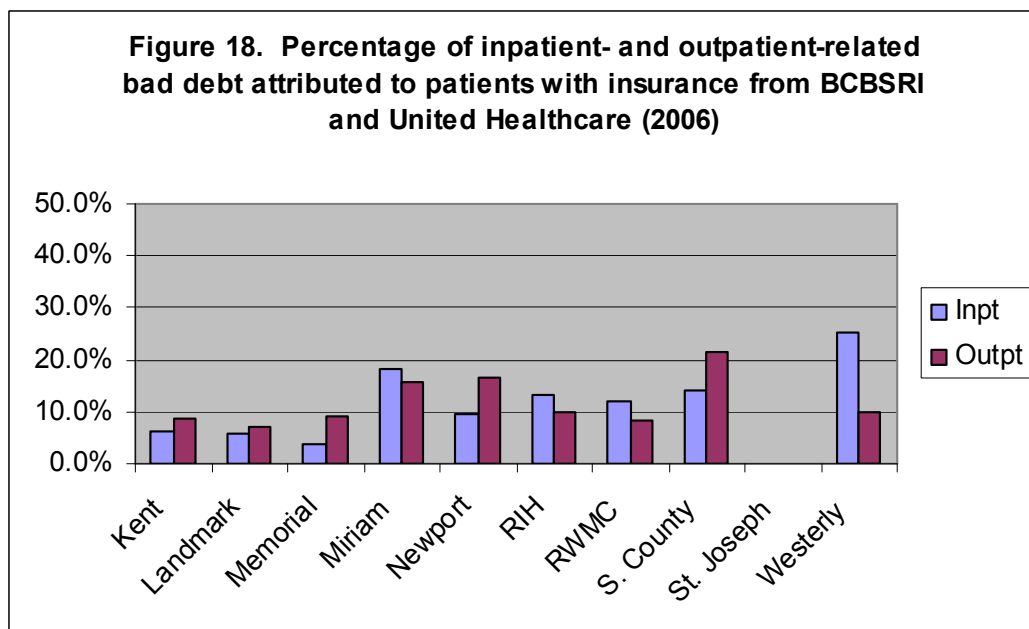
**Figure 16. Uncompensated care as a proportion of patient revenue for 8 community hospitals**



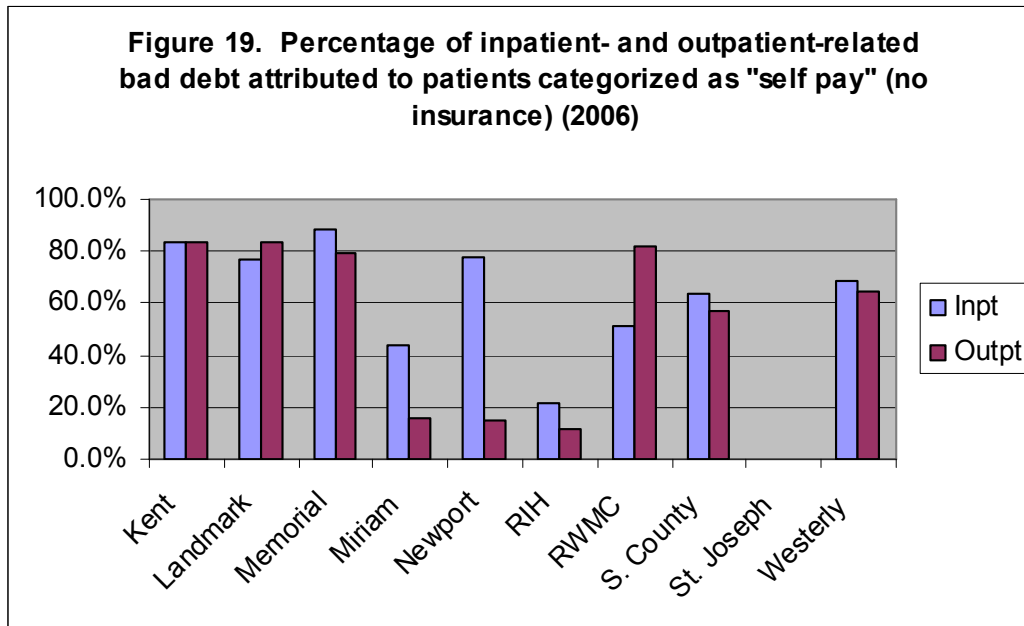
- Nearly two-thirds of all bad debt written off by hospitals is from the outpatient setting. See Figure 17, which presents data that has not been adjusted by hospitals' cost-to-charges ratio.



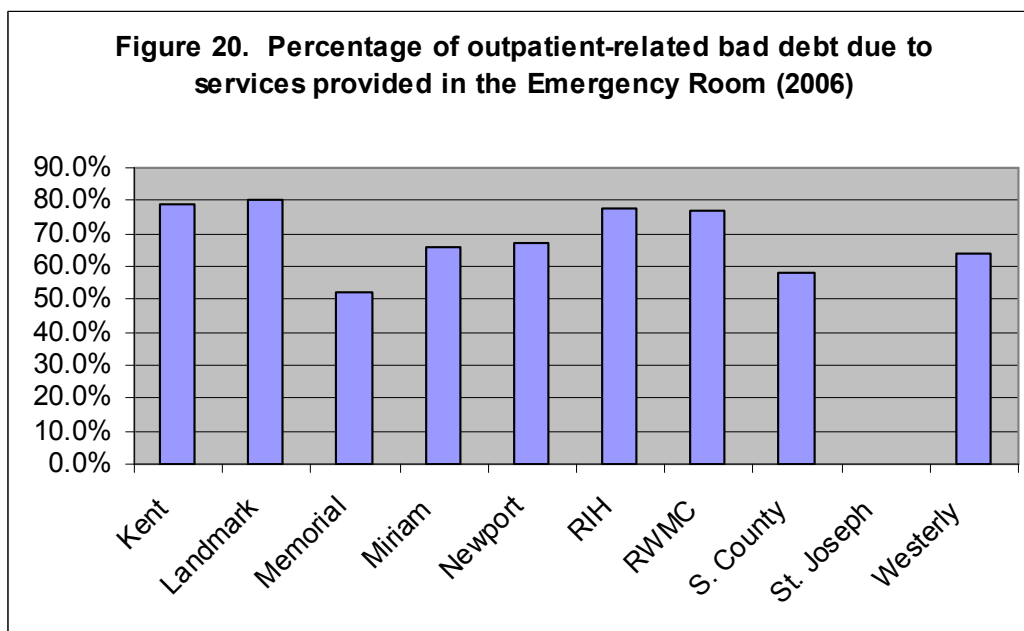
- The amount of bad debt attributable to insurers Blue Cross Blue Shield of Rhode Island and United Healthcare plans averaged around 10% of inpatient-related bad debt and 10% of outpatient-related bad debt for most in acute care general hospitals (see Figure 18; data missing for one hospital). Several Task Force members highlighted the fact that the number of Rhode Islanders enrolled in high-deductible plans is increasing, and assert that this is playing a role in increasing levels of bad debt observed by the hospitals.



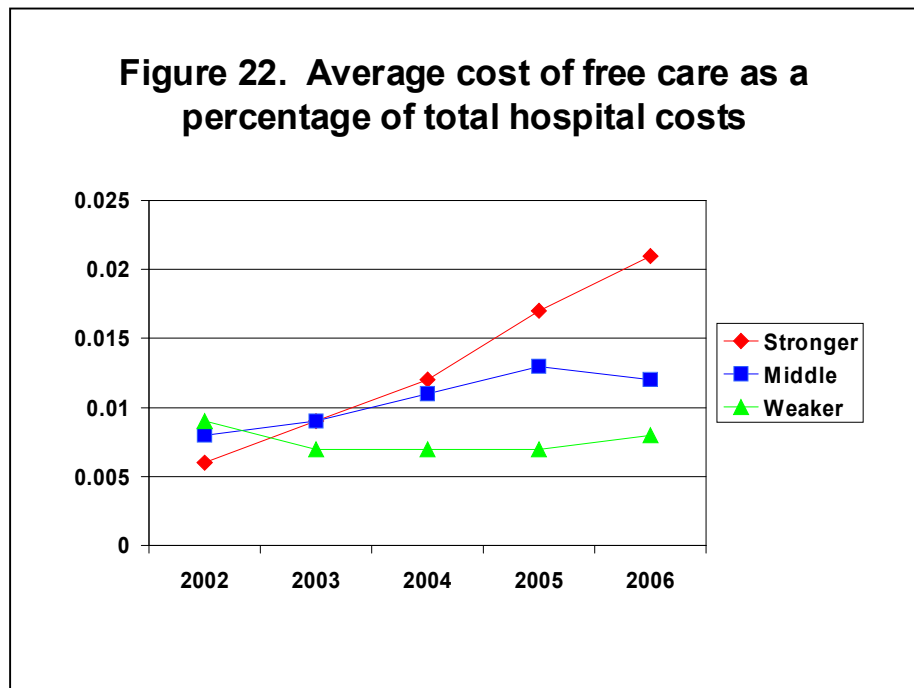
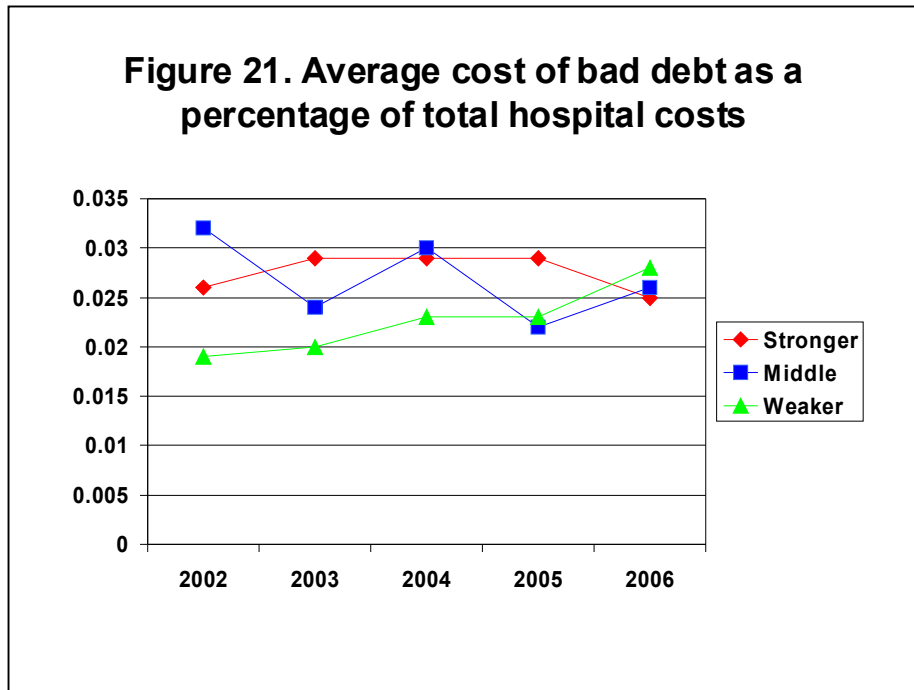
- A majority of the bad debt related to inpatient and outpatient care provided by 9 acute care general hospitals (1 missing) was attributable to patients with no insurance (e.g. classified by hospitals as self-pay) for the non-Lifespan related hospitals. [Note: The Task Force did not review any description of why the values for self pay category were much lower for Miriam, Newport, and Rhode Island Hospitals than for all the other hospitals.] See Figure 19.



- Across nine general acute care hospitals (data missing for one hospital), 75% of outpatient-related bad debt is related to Emergency Room (ER) use. See Figure 20.



- When grouped by strength of financial performance, hospitals with stronger financial performance provide the highest amount of free care as percentage of total hospital costs, and their free care as a percentage of operating cost is growing rapidly. Bad debt as a percentage of operating costs is growing fastest for weaker hospitals, reaching 2.76% in 2006. See Figures 21 and 22.



## Potential topics for further analysis

In addition to the topics addressed in the previous section, the discussion in meetings of the Task Force highlighted several topic areas that are relevant to the financial health of community hospitals, but which require more information or discussion than the Task Force's time constraints would allow. While there were many issues mentioned once or twice in the course of discussion, the issues that received the most attention are described here.

**Definition of essential services at community hospitals.** Several members of the Task Force identified a need for greater definition of the role that community hospitals have in their community, and specifically the list of services that are essential for meeting the community's needs. The definition of the role of and essential services at each of Rhode Island's hospitals is the first step in prioritizing the services that should be supported within a new regulatory and reimbursement framework. For example, a health planning process that defines essential services should be the first step designing a realigned payment system that encourages efficient and high quality care across the health care system. The corollary to this statement is that the regulatory and reimbursement framework must define and support the balance of essential services provided by community hospitals, by tertiary-level hospitals, and by outpatient ambulatory care sites in a manner that meets community expectations for quality and affordability in health care.

**Changing nature of relationship between physicians and hospitals.** Members of the Task Force, as well as hospital personnel that participated in several focus groups for the Task Force, identified increasing competition from physician-operated outpatient services as a key factor that impacts hospitals' finances. The Task Force recognized that the reasons behind this increasing competition are manifold, e.g.: lower physician reimbursement rates driving physicians to enhance the types of services they provide; little interest or ability for hospitals and physicians to pursue joint ventures; higher physician reimbursement rates in neighboring states; etc.

Additionally, the Task Force identified the convergence of two trends that have the potential to decrease the loyalty between hospitals and physicians, exacerbating the drive to refer patients to non-hospital-based services. The two trends are: 1) the increasing use of hospitalists in hospitals, which on the positive side has the potential to increase quality and standardization of hospital services, and 2) the dominance of a volume-based, fee-for-service reimbursement model for community-based physicians, which has the potential to reduce the time that physicians take to attend to their hospitalized patients and thus their investment in or affiliation with hospital-based care.

**Use of hospital endowments.** The Task Force observed that endowments are being used by some community hospitals to maintain a positive cash flow and to support routine operations. In its discussions, the Task Force identified a need for more information about the level of endowments at each community hospital, how the level of endowment compares to regional and national benchmarks, and how endowments are used by each community hospital. The question of how endowment funds should be used by a community hospital is yet to be addressed. Some Task Force members felt that endowment should not be used to subsidize hospitals that would

otherwise face losses from their routine operations under the current regulatory and reimbursement framework.

## Recommendations

Hospitals play an important role in collaboration with other providers in the health care system to achieve the goal of healthy people in healthy communities. In order to assure the ongoing financial health of community hospitals, Task Force members urge State leaders to develop specific policy actions based on these recommendations.

Task Force members agreed that the reasons behind community hospitals' financial troubles are too complex to be solved with short-term solutions. Solutions in the short-term would not likely have a sustainable impact. The only sustainable approach to addressing hospitals' ongoing financial health is to make systemic changes. In order to avert an acute crisis in the next several years, steps must be taken now to reach long-term goals for system change. Failure to do so will also result in hospitals' making independent decisions to support their own viability, rather than coordinated decisions to meet community needs.

In addition to the need for services, one vital community need is an affordable health care system. Without systemic change, the most immediate consequence of increasing payment levels to health care providers could be to increase insurance premiums and the cost of health care overall. Payments to providers should support systemic change that is instead an investment in reducing costs and improving outcomes across the health care system.

Task Force members considered a number of potential courses of action that would address the fact-based conclusions listed above. In a prioritization process, the Task Force identified which actions would have the highest positive impact on hospitals and the health care system, while also considering the time and resources needed to implement each potential action. High-impact actions became the Task Force's recommendations.

The Task Force recommends the following principles for action and specific actions, grouped here to address the two major systemic factors that are contributing to community hospitals' weakened financial conditions:

### **1. Reform payment to encourage efficient and high quality care, being mindful of the goal of affordable health care.**

The State should evaluate options for adopting a case-based payment methodology across all payers statewide that encourages efficiency, quality, and collaboration. Any revisions to payment should support ongoing efforts to create an affordable health care system.

#### *Principles*

- Commercial insurers' methodology should be designed consistent with Medicaid and Medicare and implemented with community input, including EOHHS and OHIC involvement.
- The new payment methodology should include pay-for-performance provisions.

- Payment should support primary care infrastructure and realign incentives to remove any reimbursement bias for complex services. Changes in payment should ensure that incentives are sufficient to support low-complexity and preventive services that are effective contributors to health.
- Changes in payment should be used to align financially the interests of hospitals and physicians and thus eliminate some of the competition between them.

*Actions*

- Medicaid's payment methodology should be revised by FY2010 or earlier.
- Physician reimbursement levels and methods should be examined in the next several months.

## **2. Encourage collaboration, up to and including mergers.**

State policy and hospitals' management activities should facilitate collaboration across hospitals and between hospitals and other providers. Task Force members identified specific goals for collaboration that would improve community hospitals' financial health, through their ability to reduce costs and improve quality, without leading to increased health care costs overall.

*Principles*

- A number of options exist for collaboration, ranging from informally sharing best practices to affiliation and merger.
- Through collaboration, hospitals should aim to reduce costs and increase quality, not solely enhance revenue through increased bargaining power. The state's regulatory and reimbursement framework should support this.
- Effective collaboration would address hospitals' stated need to ensure that their own capacity is used most efficiently. For example, this could be achieved by working with other providers so that patients who seek hospital services but would be better served elsewhere can receive the right care in the most appropriate setting.

*Actions*

- Specific recommendations for 2008 legislative session may include:
  - Evaluate modifying the Hospital Conversions Act.
  - Explore remedies to any barriers to collaboration posed by federal anti-trust laws.
  - Evaluate CON issues related to: a) expanding CON review beyond its current scope; b) the need for and timing of a broad-based moratorium on activities subject to CON review.
- State should conduct health planning to support policy decisions.

## Acknowledgements

The Task Force co-chairs recognize the essential contributions of the following participants in the Task Force's work:

Task Force members (See Attachment 1)

### Governor's staff

- David Burnett

### Lt. Governor's staff

- Jennifer Wood
- Dan Meuse
- Vladimir Ibarra

### Executive Office of Health and Human Services staff

- Tracey Manni
- Christine O'Connor

### Department of Health staff

- Jay Buechner
- Bruce Cryan
- Michael Dexter
- Helen Drew
- Stephanie Kissam
- Sharanya Krishnan
- Vicki Lombardi
- Lucille O'Neil
- Elizabeth Shelov
- Brenda Sullivan
- Kathy Taylor
- Bill Waters
- Donald Williams
- Kristi Zonno

### Senate staff

- Marie Ganim
- Emma Berca

### Focus group facilitators

- Adelita Orefice, Director, RI Department of Labor and Training
- Dr. Robert Crausman, Chief Administrative Officer, Board of Medical Licensure and Discipline
- Pamela McCue, RN, MS, Director of Nursing Registration and Nursing Education, Department of Health

Nancy Kane, Ph.D. and Michael Kane, MBA, consultants and authors of analysis on hospitals' financial performance

Hospital CEOs and CFOs for providing necessary data in a short time frame

Hospital Association of Rhode Island

Cranston Senior Services

Department of Labor and Training staff at NetworkRI

Members of the public who participated in Community Meetings and submitted written comments

## **ATTACHMENT 1**

### **Community Hospital Task Force Membership**

Membership comprised of 2 co-chairs, plus 18 members

#### Co-chairs

Jane A. Hayward, Secretary of EOHHS,  
Dr. David R. Gifford, Director, Department of Health

#### State Government Officials

Gary Alexander, Director, Department of Human Services  
Christopher F. Koller, Health Insurance Commissioner

#### Hospital Administration

Louis Giancola, CEO, South County Hospital

#### Community Hospital Board Members

Fred Allardyce, Westerly Hospital  
Andrew M. Erickson, Kent Hospital  
Paul Mooney, Memorial Hospital  
Daniel Ryan, St. Joseph Health Services of Rhode Island

#### Insurance

Stephen Farrell, CEO, United Healthcare of New England  
James Purcell, CEO, Blue Cross Blue Shield of Rhode Island

#### Healthcare Provider

J. Russell Corcoran, MD, FACP, South County Hospital (Primary Care Leadership Council representative)  
Alicia Monroe, MD, primary care physician, Memorial Hospital (RIMS representative)  
Sharon Smith, RN, Board of Nursing, Surgical Nurse, Westerly

#### Consumers

Sam Havens  
Bernadette Hawes

#### Business

Herb Gray, Rhode Island Business Group on Health

#### Legislature

Representative Steven M. Costantino, chairperson, House Committee on Finance  
Senator Stephen D. Alves, chairperson, Senate Committee on Finance  
Senator Rhoda Perry, chairperson, Senate Committee on Health and Human Services

## ATTACHMENT 2








### Community Hospital Task Force Meetings





<b>TYPE</b>	<b>DATE</b>	<b>TIME</b>	<b>LOCATION</b>
<b>Task Force</b>			
Meeting #1	April 24, 2007	7:30 – 9:30 AM	DLT
Meeting #2	May 7, 2007	5:00 – 6:30 PM	DOA
Meeting #3	May 30, 2007	7:00 – 10:00 AM	Network RI
Meeting #4	June 11, 2007	5:00 – 7:00 PM	Cranston Senior Center
Meeting #5	June 25, 2007	5:00 – 7:00 PM	NetworkRI
Meeting #6	July 9, 2007	4:00 – 8:00 PM	Network RI
Closing meeting	July 13, 2007	7:30 – 9:00 AM	State House
<b>Community</b>			
Key Stakeholders & Public	April 30, 2007	7:00 – 9:00 PM	North Providence H.S.
	May 2, 2007	7:00 – 9:00 PM	Narragansett H.S
	June 28, 2007	7:00 – 9:00 PM	Toll Gate H.S., Warwick
<b>Focus Group</b>			
CEO	April 17, 2007	3:30 – 5:30 PM	DLT
CFO	April 17, 2007	5:30 – 7:00 PM	DLT
Chief Nursing Officers	May 3, 2007	1:00 – 2:30 PM	DLT
Medical Executive Committee	May 4, 2007	9:30 – 11:00 AM	DLT
Hospital Board	May 14, 2007	5:00 – 6:30 PM	DLT

## ATTACHMENT 3





### Annotated Source List

#### Community and hospital input

1. [Summary of Themes from Community Meetings](#)  Community meetings were held April 30<sup>th</sup> in North Providence and May 2<sup>nd</sup> in Narragansett. This two-page document summarizes the main themes raised by community members at these meetings.
  2. [Transcript from April 30th Community Meeting](#) 
  3. [Transcript from May 2nd Community Meeting](#) 
  4. [Focus Group notes – Chief Executive Officers.](#) The CEOs of hospitals in Rhode Island met on April 17<sup>th</sup> to provide input on these two questions: What challenges do community hospitals face? What are the main reasons that community hospitals face financial distress?
  5. [Focus Group notes – Chief Financial Officers.](#) The CFOs of hospitals in Rhode Island met on April 17<sup>th</sup> to provide input on these two questions: What challenges do community hospitals face? What are the main reasons that community hospitals face financial distress?
  6. [Focus Group Notes/Chief Nursing Officers \(Mtg. 2\)](#) . The Chief Nursing Officers of hospitals in Rhode Island met on May 3<sup>rd</sup> to provide input on the following questions: What services should be provided by every community hospital to meet community needs? What challenges would a community hospital face in providing those services and filling those roles? What challenges does the community hospital face *now* in providing services to meet community needs? What reforms would help a community hospital address those challenges?
  7. [Focus Group Notes/Hosp. Medical Executive staff \(Mtg.2\)](#)  The chief medical executive staff members of hospitals in Rhode Island met on May 4<sup>th</sup> to provide input on the following questions: What services should be provided by every community hospital to meet community needs? What challenges does the community hospital face *now* in providing services to meet community needs?
  8. [Focus Group Notes 051207](#) . The chairperson (or designee) of each community hospital's Board of Directors/Trustees met on May 14<sup>th</sup> to provide input on the following questions: How do board members make strategic decisions? What are the challenges in making those decisions? What is the group's reaction to the Task Force's framework for organizing discussion of challenges/solutions facing community hospitals: effective structure, fair treatment, and realigned payment?
- April 24, 2007 - Meeting #1. Goal: Review process for Task Force & agree on set of challenges facing community hospitals that will be focus of Task Force work.**
9. [April 24th Task Force Mtg. Agenda](#) 

10. [April 24th Task Force Mtg. Notes](#)  Summary of discussion at Task Force Meeting 1 on April 24, 2007.
11. [Definition of Community Hospital](#). The Community Hospital Task Force reviewed this working definition at its first meeting.
12. [Consolidated Financial Statements of RI Hospitals \(Mtg. 1\)](#)  - This document compiles the consolidated financial statements submitted to the RI Department of Health for 10 non-single-specialty hospitals in Rhode Island.
13. [Health of RI Hospitals 2005 \(Mtg. 1\)](#) . This is a report published by the RI Department of Health. It summarizes measures of hospitals' financial health and compares them to regional and national benchmarks.
14. [Hospital Capital Investment in RI 2005 \(Mtg. 1\)](#)  This is a report published by the RI Department of Health. It "examines the capital structure of Rhode Island's 13 hospitals, with five objectives: 1) to identify the capital base and amount of new capital investment, 2) to analyze that investment in terms of financing mix and associated costs, 3) to present a measure of the 'adequacy' of this investment in terms of maintaining the existing capital base, 4) to examine the ability to acquire new capital, and 5) to summarize and rank the capital structure of each hospital."
15. [New York Commission on Health Care Facilities in the 21st Century \(Mtg. 1\)](#). New York State created a Commission to "review and strengthen New York State's acute and long term care delivery systems." The Commission's final report is posted on this website. The report describes the methodology the Commission used to examine the financial situation of New York's hospitals and makes recommendations for change.


**May 7, 2007 – Meeting #2. Goal: Describe community input on the integral services of community hospitals. Understand volume of those services across hospitals in RI.**


16. [May 7th Task Force Mtg. Agenda](#) 
17. [May 7th Task Force Mtg. Notes](#) . Summary of discussion at Task Force Meeting 2 on May 7, 2007.
18. [Hospital Profiles / Information on Volume & Length of Stay \(Mtg. 2\)](#) This Excel document summarizes some key characteristics of hospitals, including occupancy rates, volume of out-of-state residents, recent annual volumes by key procedures and populations, and average lengths of stay for pediatric patients.
19. [Discharge Trends by Hospital \(Mtg. 2\)](#) . This graphic illustrates inpatient volume at 10 hospitals in Rhode Island, 2002-2006.
20. [Trends in Out-of-state Residents Receiving Care in RI \(Mtg. 2\)](#) . This graphic illustrates statewide volume of out-of-state residents receiving inpatient care at 10 hospitals in Rhode Island, 2002-2006.


21. [MA not-for-profit Hospitals' Financial Status Report \(Mtg. 2\)](#). This is a working document that discusses some of the structural factors that influence the financial challenges faced by not-for-profit hospitals in Massachusetts.


**May 30, 2007 – Meeting #3. Goal: Understand the nature of hospitals’ financial condition; the incentives inherent in hospital payment methods; and the mix of inpatient and outpatient services provided by hospitals. Apply understanding to developing Task Force recommendations.**

22. [May 30th Task Force Mtg. Agenda](#) 


23. [May 30th Task Force Mtg. Notes](#) . Summary of discussion at Task Force Meeting 3 on May 30, 2007.


24. [Hospital Acute Inpatient](#)  - This six-page overview of the "Hospital Acute Inpatient Services Payment System" from October 2006 describes the basic payment methodology that Medicare uses to reimburse hospitals for inpatient stays. It discusses base payment amounts, Diagnosis Related Group (DRG) relative weights, adjustments for market conditions, and other adjustments for characteristics such as any indirect medical education provided by the hospital

25. [Hospital Inpatient and Outpatient](#)  - This document, dated March 2007, includes the Medicare Payment Advisory Commission's (MedPAC's) recommendations regarding inpatient and outpatient payment rates. This report discusses the reasoning behind these recommendations and presents some analysis of national trends in hospital margins, mix of inpatient and outpatient services, and Medicare payments.


26. [2007 Financial Tables 052907](#) . This document summarizes some key financial ratios for 8 community hospitals.


27. [Hospital Payment Methodologies](#). This document summarizes the various methodologies used to reimburse hospitals and the variation in average payment amounts by payer across Rhode Island’s 8 community hospitals.

28. [% Inpatient Discharges by Payer](#) . This document summarizes the trends in payer mix for each of Rhode Island’s 8 community hospitals, FY2002-2006.

29. [Inpatient Summary FY 05](#) . This document describes Medicaid Fee-For-Service payments for inpatient stays at Rhode Island’s hospitals.

30. [Medicare payments](#). This document summarizes the various payments that Medicare makes to Rhode Island’s hospitals.

31. [Medicare Cost Report OP Revenues](#)  This graphic illustrates outpatient revenues for each hospital as a proportion of total revenues.

32. [Medicare Margins](#)  This document provides excerpts of tables from the March 2007 MedPAC report (posted elsewhere on this site) that illustrate the trends in average Medicare margins across all of the nation's hospitals.

**June 11, 2007 - Meeting #4. Goal: Understand the drivers of hospitals' financial condition. Apply understanding to developing Task Force recommendations.**

33. June 11<sup>th</sup> [Agenda](#)

34. June 11<sup>th</sup> [Meeting notes](#)

35. [Uncompensated care summary](#). This document defines uncompensated care and two of its components, bad debt and charity care. The document provides data on trends in uncompensated care across hospitals in Rhode Island. The document also puts trends in uncompensated care in the context of overall hospital revenues.

36. [Hospital costs – Medicare data](#). This one-page summary includes 2 charts: 1) Case mix adjusted Medicare average length of stay, and 2) Case mix adjusted cost per discharge. The charts demonstrate variation across Rhode Island's 8 community hospitals in both average length of and cost per discharge.

37. [Drivers of financial performance of hospitals in Rhode Island – presentation](#). This presentation was developed and delivered by Nancy and Michael Kane, consultants to the Community Hospital Task Force, at the June 11<sup>th</sup> meeting.

**June 25, 2007 - Meeting #5. Goal: Discuss and verify key findings of the Task Force that are based on data and materials reviewed by the Task Force. Draft list of conclusions based on discussion of final set of findings.**

38. [Summary of the Hospital Conversions Act](#). This document describes the historical context in which the Hospital Conversions Act (Rhode Island General Laws Chapter 23-17.14) was passed and its consequences.

39. [Summary of the Certificate of Need program](#). This document describes the conditions in which a Certificate of Need is required for facility construction, capital expenditures, or initiation of some tertiary care services in health care facilities.

40. [Memo to the Tertiary Care Committee from Department of Health staff](#). This document, dated April 17 2007, describes the findings reviewed by the Tertiary Care Committee regarding the volume-quality relationship of certain tertiary care services.

41. [June 25<sup>th</sup> Meeting Agenda](#)

42. [June 25<sup>th</sup> Meeting Notes](#)

43. [Working document – Revised Findings \(based on Task Force input on 6/25\)](#). This document is a preliminary set of findings based on feedback from the Community Hospital Task Force at the June 25th meeting.

**July 9, 2007 - Meeting #6. Goal: Analyze potential courses of action for system changes and develop a list of recommended actions based on the Task Force’s findings and conclusions.**

44. July 9<sup>th</sup> Meeting Agenda

45. [July 9<sup>th</sup> Meeting Notes](#)