HMA

Rhode Island Office of Attorney General

Statewide Health Care Capacity Assessment

May 2025

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Executive Summary

To gain insight into the current state of health care in Rhode Island, including the impact of post-COVID-19 challenges on health care providers in Rhode Island, the Rhode Island Office of the Attorney General (Office) engaged Health Management Associates (HMA) in October 2023 to evaluate the capacity of hospitals, long-term care facilities, and the sufficiency of primary care providers across the state. This comprehensive evaluation seeks to gauge the existing capacity of health care providers in Rhode Island, determine whether current capacity aligns with the present and anticipated demands of the state's residents, and, most importantly, inform strategic health policy decisions moving forward.

Hospitals

1. Hospital utilization rates in Rhode Island, nominal and adjusted for population, are decreasing faster than the national average. Further assessment is needed to understand the cause of this difference and its potential impact on future demands for acute care beds.
2. The average daily census (ADC) of Rhode Island hospitals is 62% of total licensed beds, indicating a misalignment of supply and demand. Further research is needed.
3. Emergency department (ED) performance in Rhode Island lags the nation, with Rhode Islanders twice as likely as the nation to leave the ED without being seen. This indicates potential ED staffing and capacity issues, overutilization tied to a lack of primary care access, and a lack of staffed acute care beds available to accommodate demand.
4. Stakeholder feedback and recent reports about Rhode Island's hospitals suggest that the state's comparatively lower hospital reimbursement is at least one underlying cause of the aforementioned trends.

Long-term Care

1. Nursing home closures and the overall reduction in nursing home occupancy in Rhode Island since 2015 exceeded the national rate despite a higher percentage of the population over 65.
2. Rhode Island's percentage of nursing homes operated as for-profit entities (87%) is higher than the national average (71%).
3. In Rhode Island, over 60% of the Medicare population is enrolled in Medicare Advantage (MA) plans.[1] According to key informant interviews, Rhode Island's main MA plans have not adjusted post-acute care rates in nearly ten years, significantly trailing behind fee-for-service rates. This disparity and insufficient Medicaid reimbursement may contribute to the lack of post-acute beds for patients discharged from acute hospitals.

Primary Care

1. Compared to other states, Rhode Island has among the highest number of primary care providers per capita. Recent reports and stakeholder feedback suggest this information may lead to inaccurate conclusions about the actual availability of providers to patients seeking a primary care appointment. Further study is necessary.

[1] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, KFF, "Medicare Advantage in 2024: Enrollment Update and Key Trends," *https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/*.

2. While Rhode Island ranks favorably among the nation's primary care physicians (PCPs), they are not evenly distributed throughout the state, creating pockets of significantly lower PCP sufficiency.

Introduction

Following the COVID-19 Public Health Emergency, health care providers nationwide grapple with formidable challenges in delivering essential health care services. COVID-19 has exposed and amplified longstanding vulnerabilities within the health care system, creating a ripple effect that continues to impact the industry in this post-pandemic era. Widespread workforce shortages, financial pressures, disparities in access to care among vulnerable populations, and a sharp increase in behavioral health demands have added immense strain to an already complex health care landscape. These challenges have resulted in overcrowded emergency departments, a growing demand for long-term care beds, and prolonged wait times for primary care provider appointments, highlighting the urgent need for strategic solutions to navigate the evolving health care delivery environment.

To gain insight into the impact of these challenges on health care providers in Rhode Island, The Rhode Island Office of the Attorney General (Office) engaged Health Management Associates (HMA) in October 2023 to evaluate the capacity of hospitals, long-term care facilities, and the sufficiency of primary care providers across the state. This comprehensive evaluation seeks to gauge the existing capacity of health care providers in Rhode Island, determine whether current capacity aligns with the present and anticipated demands of the state's residents, and, most importantly, inform strategic health policy decisions moving forward.

Our assessment of health care service capacity in Rhode Island involved three primary resources: recent literature, quantitative data analysis, and interviews with key stakeholders. By combining these resources with a thorough understanding of prevailing health care delivery trends, HMA could comprehensively and effectively evaluate Rhode Island's providers' ability to address resident health care needs. HMA utilized publicly available data to conduct the quantitative analysis aspects of the assessment. In 2020 and 2021, COVID-19 significantly impacted health care utilization patterns, including reduced emergency department visits, elective procedure delays, increased telehealth use, and decreased hospital admissions. These trends began to reverse in 2022 as the pandemic subsided. COVID-19, however, disrupted trend analysis accuracy over the past five years.

Furthermore, variations in methodology across different data sources created quantification discrepancies. Our approach enabled us to perform directional trend analysis and derive valuable insights for strategic decision-making, though it will take several more years of data to evaluate post-COVID-19 trends fully. HMA's implementation of an interactive data analytics tool was provided to the Office to perform targeted queries within the databases utilized for this study.

Stakeholders interviewed (see *Appendix A* for a complete list) by HMA expressed gratitude for the Office's proactive stance in addressing health care provider challenges and recognizing the current health care crisis. A common sentiment among stakeholders was the importance of fostering collaboration among providers, community organizations, and government departments, such as the Offices of The Health Insurance Commissioner and Health and Human Services. They note additional efforts underway with the Governor's State Health Care System Planning (HCSP) Cabinet established by Governor Dan McKee by executive order on February 21, 2024.[2]

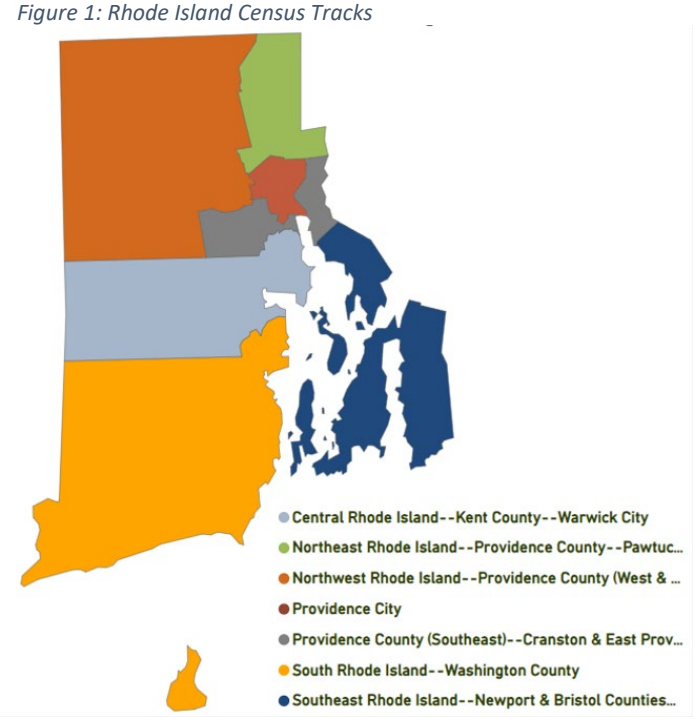
[2] R.I. Executive Order 24-04, February 21, 2024, https://governor.ri.gov/executive-orders/executive-order-24-04.

Rhode Island Population

Rhode Island's population was evaluated to understand its potential influence on health care provider demand. Rhode Island's population increased 4.3% from 2010 to 1,097,379 in 2020.[3] This growth rate is lower than the national average of 7.4%, though consistent with Northeastern states' 4.1% average increase.[4] Rhode Island is the second most densely populated state.[5] The high population density in Rhode Island results in a greater demand for health services per square mile.

Rhode Island has a diverse population with significant Hispanic (16.6%), Black (5.7%), and Asian communities (3.6%), primarily concentrated in the Providence City and Northeast areas of the state.[6] The state's population skews older compared to the national average and neighboring states (Connecticut and Massachusetts), influencing the utilization of health care services (Table 1).

Figure 1: Rhode Island Census Tracks



Demographics by Census Tracts

HMA used Rhode Island's seven census regions, shown in Table 1, to evaluate population and provider utilization variations across the state. While acute care hospitals located in each census area are noted, hospital utilization crosses census areas, especially for tertiary care facilities that serve the high acuity needs of a large region. Gender demographics averaged 50% female and 50% male. Population trends indicate Rhode Island will likely experience relatively slow or negative population growth driven by outmigration, more deaths than births, and an increasingly aging population. Over time, this trend toward an older population will likely drive increased health care utilization, including long-term care.

Table 1: Rhode Island Population Demographics by Census Areas[7]

Census Area, Total Population 2020	Acute Hospitals	0-64	65-74	75+	White	Black	Asian	Hispanic
Northeast, 189,868	Our Lady Fatima Hospital	85%	9%	7%	68%	9%	2%	23%
Central, 169,291	Kent County Memorial Hospital	81%	11%	8%	89%	2%	3%	5%
Southeast, 136,170	Newport Hospital	82%	10%	8%	89%	3%	2%	5%

[3] United States Census Bureau, "Rhode Island's Population Grew 4.3% Last Decade," https://www.census.gov/library/stories/state-by-state/rhode-island-population-change-between-census-decade.html.
[4] United States Census Bureau, "Historical Population Change Data (1910-2020)," https://www.census.gov/data/tables/time-series/dec/popchange-data-text.html.
[5] United States Census Bureau, "Population Density of the 50 States, the District of Columbia, and Puerto Rico: 1910 to 2020," https://www2.census.gov/programs-surveys/decennial/2020/data/apportionment/population-density-data-table.pdf.
[6] *Supra* n. 3.
[7] U.S. Census Bureau. (n.d.). *Rhode Island – Census Bureau Profile,* U.S. Department of Commerce, 2020, from https://data.census.gov/

Providence City, 188,842	Miriam Hospital, RI Hospital, Roger Williams Medical Center, Women and Infants Hospital	88%	7%	5%	50%	16%	6%	43%
South, 130,266	Westerly Hospital, South County Hospital	79%	13%	8%	92%	1%	2%	3%
Northwest, 147,888	Landmark Medical Center	82%	11%	8%	84%	3%	3%	11%
Providence County, 129,624	None	83%	10%	8%	78%	6%	5%	12%
Total: 1,095,962	All	83%	10%	7%	77%	6%	3%	16%

Hospital Utilization

Rhode Island has 12 acute care hospitals, not including the Providence Veterans and Rhode Island Rehabilitation Hospitals, with 2,805 licensed beds. Determining the exact number of licensed beds that are staffed and available for use is only possible by directly surveying each hospital. The only publicly available information on staffed beds is the self-reported numbers in the hospitals' Medicare cost reports. The latest available annual cost reports for the period ending September 30, 2023, indicate 2,572 (92%) licensed beds are staffed in the 12 acute care hospitals.[8] Based on national data and stakeholder input, it is reasonable to expect the number of available beds at any given time to be fewer than the self-reported staffed beds due to staffing and volume fluctuations. Some states have mandated daily reporting of available beds driven by COVID-19 need for regional and state-wide planning. The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), in partnership with Rhode Island Quality Institute (RIQI), maintains a website to provide public information about bed availability for mental health and substance use disorder services.[9] Expanding this to include all beds would facilitate acute care bed capacity analysis. Table 2 details licensed and reported staffed beds for each Rhode Island hospital.

Currently, two hospitals (17%) operate as for-profit entities, with the remaining as nonprofits. This is a similar ratio to the US, where 24% of hospitals are for-profit. Only one (7%) hospital in Rhode Island is independent or not part of an extensive hospital system compared to 32% of hospitals nationally.[10]

HMA analyzed utilization data from the Rhode Island Department of Health Hospital Discharge Data database for 2020 to June 2023. Discharges represent the completion of an inpatient stay, making it a standard measure of hospital utilization that is comparable across hospitals over time. Due to seasonal hospital utilization variations, 2022 data was used. Annualizing 2023 partial-year data (Jan – June) for comparison may lead to inaccuracies.

Table 2: IP Acute Care Hospitals in Rhode Island, Total Bed Capacity, Discharges and Ownership[11]

		DISCHARGES			
Acute Care Hospital	**Licensed / Staffed Beds**	**2020**	**2022**	**Change**	**Hospital System**
Academic Medical Center					
The Miriam Hospital	247/247	16,429	14,956	-9.0%	Nonprofit (Lifespan)

[8] American Hospital Directory, https://www.ahd.com/

[9] BH Link, Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, https://www.ribhopenbeds.org/.

[10] American Hospital Association, "Fast Facts on Hospitals, 2024," https://www.aha.org/statistics/fast-facts-us-hospitals.

[11] **Licensed Beds**: Rhode Island Department of Health, "Licensee Lists," https://health.ri.gov/lists/licensees/; **Staffed Beds**: American Hospital Directory, https://www.ahd.com/; **Discharges**: Rhode Island Department of Health, Hospital Discharge Data 2020-2022.

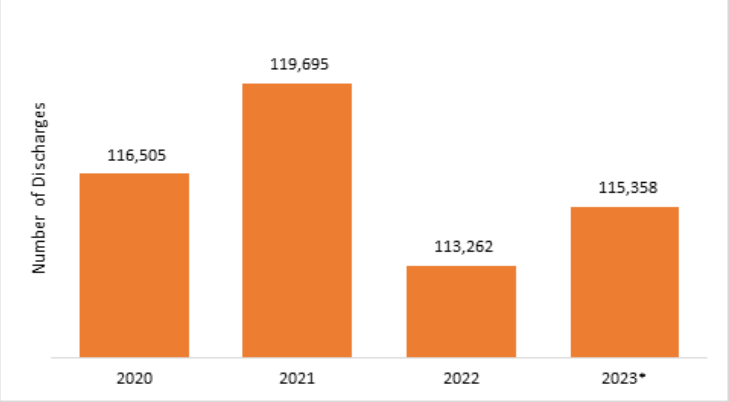
Rhode Island Hospital (and Hasbro Children's Hospital)	719/706	31,347	29,175	-6.9%	Nonprofit (Lifespan)
Community Acute Care					
Kent County Memorial Hospital	359/343	12,364	12,569	1.7%	Nonprofit (Care New England)
Landmark Medical Center	214/141	6,134	6,154	0.3%	Nonprofit (Prime)
Newport Hospital	129/109	4,824	5,125	6.2%	Nonprofit (Lifespan)
Our Lady of Fatima Hospital	312/312	4,475	4,525	1.1%	Proprietary (CharterCARE)
Roger Williams Medical Center	220/160	6,671	5,627	-15.7%	Proprietary (CharterCARE)
South County Hospital Inc.	100/79	6,792	6,121	-9.9%	Nonprofit
Westerly Hospital	125/95	3,212	3,413	6.3%	Nonprofit (Yale New Haven Health)
Other					
Butler Hospital (Adolescent and Adult Psychiatric)	143/143	5,065	6,412	26.6%	Nonprofit (Care New England)
Emma Pendleton Bradley Hospital (Pediatric Psychiatric)	70/70	840	652	-22.4%	Nonprofit (Lifespan)
Women and Infants Hospital of Rhode Island (Obstetrical)	167/167	18,352	18,533	1.0%	Nonprofit (Care New England)
TOTAL	**2,805/2,572**	**116,505**	**113,262**	**-2.8%**	

Hospital Utilization Trends

As seen nationally, hospital inpatient utilization trends in Rhode Island continue to decline, influenced by changes in reimbursement methodologies, technological advancements, and shifts from inpatient to outpatient care. This overall decline in inpatient utilization is more pronounced in Rhode Island compared to the national average. As described below, utilization trends were disrupted from 2020 to 2021 due to COVID-19. Published literature cites several causes for these acute, COVID-related decreases in hospital volume, including cancellation of elective procedures, patient avoidance of hospitals (deferred care), reduced accidents, and disease transmission due to stay-at-home orders.[12]

As described in data from the American Hospital Association (AHA), national hospital admissions are declining, dropping 7% from 2018 to 2022.[13] In Rhode Island, they decreased by 15.5% over the same period.[14] HMA compared discharge data for 2020 to 2022 (the most recent post-pandemic year), offering a more focused analysis of recent utilization trends in COVID and post-COVID periods.

*Figure 2: Inpatient Discharges by Year (*2023 Annualized)*



Changes in discharges from 2020 to 2022 reflect an initial decrease in utilization at the height of the pandemic, followed by an uneven rebound in utilization. Discharges decreased 2.8% from 2020 to 2022,

[12] John D. Birkmeyer, Amber Barnato, Nancy Birkmeyer, Robert Bessler, and Jonathan Skinner, "The Impact Of The COVID-19 Pandemic On Hospital Admissions In The United States," Health Affairs, https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00980.

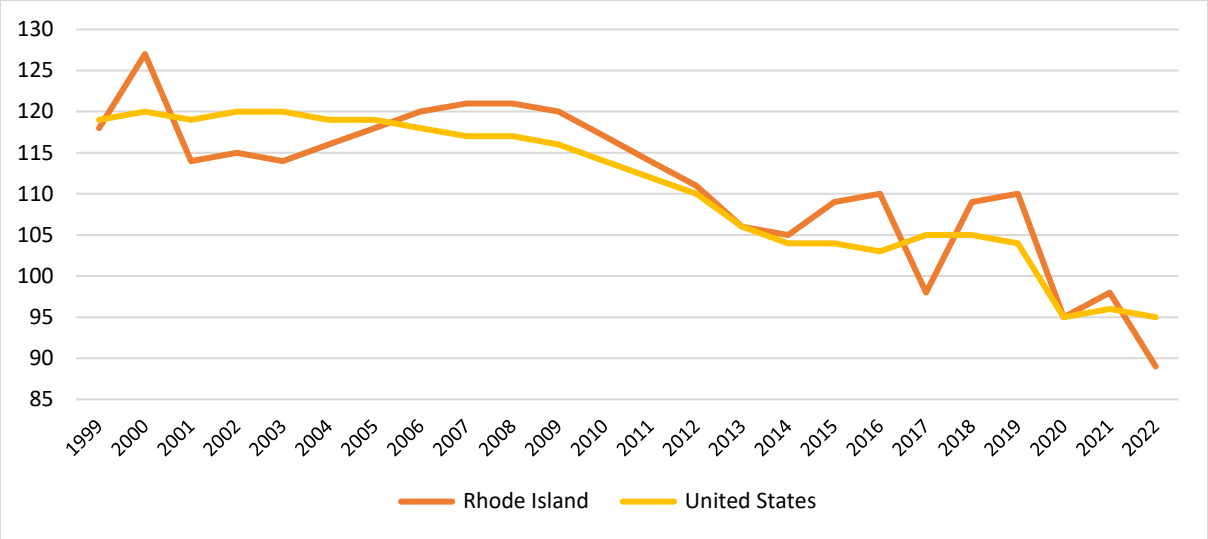
[13] 2024, AHA Hospital Statistics, Health Forum LLC, an affiliate of the American Hospital Association.

[14] *Id.*

following persistent national trends. However, these trends vary significantly among the 12 Rhode Island hospitals. Most acute care hospitals' discharge numbers recovered from COVID-19 disruptions. Newport and Westerly experienced the most significant percent increase in discharges. Other hospitals did not. Notably, Roger Williams experienced a substantial 15.7% decrease in discharges during this period. Butler experienced the most significant percentage increase among psychiatric hospitals, likely offsetting a corresponding large percentage decrease at Bradley. Further study is necessary to determine the underlying cause of these variations across hospitals (e.g., were services added or discontinued, were managed care contracts added or terminated, and was there a gain or loss of admitting physicians, nurses, and other professional staff.)

Looking at population-adjusted admission rates, Rhode Island inpatient admissions are down, which is also true nationally, as shown in Figure 3. Admission rates in 2022 were even lower in Rhode Island, with 89 admissions per 1,000 people compared to 95 per 1,000 nationally. Further study is necessary to determine why Rhode Island admission rates are falling faster than the national average.

Figure 3: US and Rhode Island Admissions per 1,000 People



HMA also evaluated the average daily census for each hospital and the state. The average daily census (ADC) refers to the average number of inpatients in the hospital daily. It is calculated by dividing the total number of inpatient days by 365 days. Figure 3 demonstrates that, on average, Rhode Island hospitals experienced a decline in ADC in 2020 due to the impact of COVID-19 (seven of 12 hospitals experienced a decrease, and the other five increased ADC in 2020), then all rebounded in 2021.

Although the total number of licensed beds staffed is 92% of all licensed beds according to recent Medicare cost reports (Table 2), ADC for Rhode Island's 12 acute care hospitals suggests that only 62% of licensed beds are being utilized. In general, ADC may be influenced by several factors, including a hospital's ability to staff and otherwise fully resource their inpatient beds and patient demand. Notably, stakeholders' observations (described below) highlight a persistent shortage of health care workers, with hospitals struggling to recruit and retain workers. This may serve as a limiting factor on hospitals' ability to take new patients, thereby lowering their ADC. The disparity between licensed beds and ADC in Rhode Island hospitals requires further study to understand this discrepancy.

Recent trends of categorizing patients staying in the hospital as observation (awaiting determination of the need to admit), meaning that they are considered outpatient, may impact the ability to evaluate trends accurately. The significant decrease in ADC in 2022 is of concern, mainly in Rhode Island Hospital

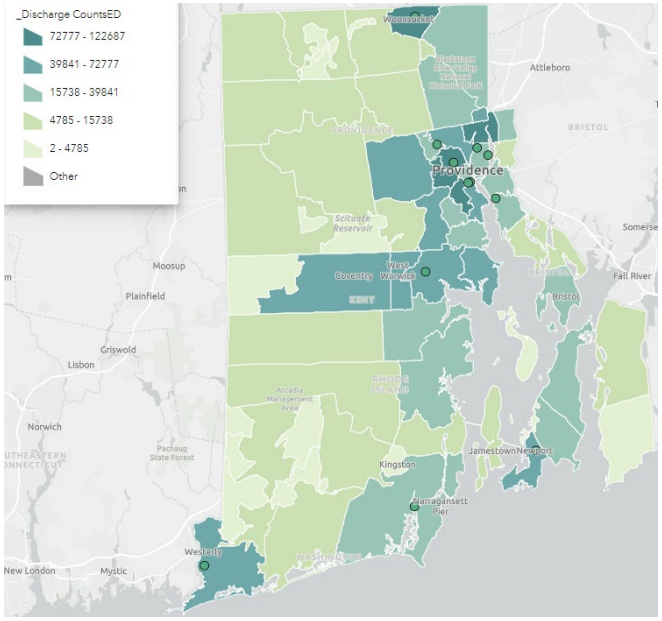
and Kent County Memorial Hospital. Further study is needed to determine the cause of this decline, which may include increased categorization of patients as observation and staffing limitations.

Figure 4: Hospital and Patient Heatmap Based on ED Discharge Counts

IP-Average Daily Census by Hospital

Hospital Name	2018	2019	2020	2021	2022
RHODE ISLAND HOSPITAL	572.93	560.59	544.91	609.88	568.34
THE MIRIAM HOSPITAL	204.29	201.49	184.66	205.01	197.67
WOMEN & INFANTS HOSPITAL OF RHODE ISLAND	205.78	193.94	185.47	185.05	193.82
KENT COUNTY MEMORIAL HOSPITAL	188.00	179.42	171.44	198.83	175.82
BUTLER HOSPITAL	123.87	115.27	96.41	97.07	139.87
OUR LADY OF FATIMA HOSPITAL	96.50	97.20	89.08	93.72	82.63
ROGER WILLIAMS MEDICAL CENTER	88.25	90.27	88.24	85.47	75.71
NEWPORT HOSPITAL	69.70	66.68	72.98	85.47	86.09
LANDMARK MEDICAL CENTER	68.19	68.97	76.76	86.00	78.75
EMMA PENDLETON BRADLEY HOSPITAL	68.49	65.71	65.36	65.63	68.30
SOUTH COUNTY HOSPITAL INC	55.07	53.82	55.82	60.50	56.26
WESTERLY HOSPITAL	31.02	36.48	51.81	55.44	55.17
Total	**1,772.08**	**1,729.82**	**1,682.95**	**1,828.08**	**1,778.43**

Emergency Departments



ED's are a vital community resource and a significant source of hospital inpatient admissions. One methodology to evaluate emergency department and hospital capacity is the number of patients boarding (waiting for an inpatient bed). High boarding numbers indicate ED (and inpatient hospital) overcrowding and, therefore, insufficient capacity, both in the EDs and inpatient settings. Hospitals collect and monitor this information; however, it is not publicly reported in Rhode Island. This study utilized publicly reported ED utilization and efficiency data to evaluate ED capacity.

Left without being seen (LWBS) rate is correlated and used as a proxy measure for ED crowding.[15] High volumes, inappropriate ED utilization, increasing acuity, short staffing, and poor operational efficiency cause crowding, leading to boarding and individuals presenting for care who left without being seen.

Nationally, emergency visits declined by 4.5% from 2018 to 2022, whereas in Rhode Island, they decreased by 11.7% over the same period.[16] More recently, during the COVID and post-COVID period, ED visits in Rhode Island increased 19.2% from 2020 to 2022. However, this growth was unevenly distributed, with nonprofit hospitals experiencing a 22% increase compared to only 3% in the two for-

[15] Carter EJ, Pouch SM, Larson EL. The relationship between emergency department crowding and patient outcomes: a systematic review. J Nurs Scholarsh. 2014 Mar;46(2):106-15. doi: 10.1111/jnu.12055. Epub 2013 Dec 19. PMID: 24354886; PMCID: PMC4033834.

[16] AHA Hospital Statistics, 2024.

profit hospitals and Landmark Medical Center. Further investigation is needed to understand the causes of this disparity.

A stakeholder explained: "…a significant challenge exists stemming from the lack of access to primary care, leading to a domino effect that notably increases patient volumes in emergency rooms (ERs) and urgent care centers. This issue was particularly evident in 2022 and the subsequent winter, when there was a concerted effort through active communication and messaging to encourage people to avoid ERs and urgent care facilities because they were overwhelmed. This highlights a systemic problem where inadequate access to primary care forces residents to seek ED care, leading to overcrowding and strained hospital services."

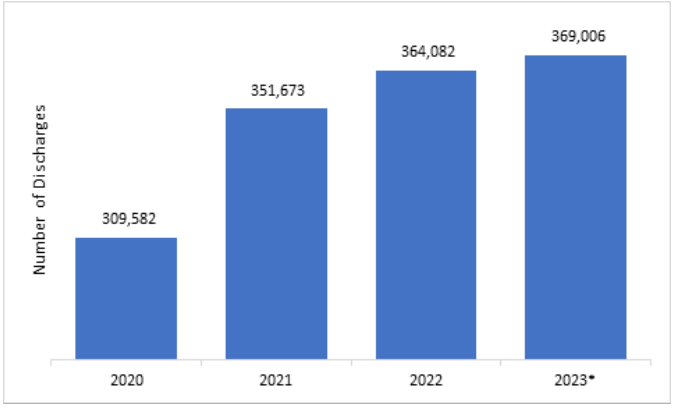
ED utilization in Rhode Island shows an opposite trend compared to inpatient utilization. Rhode Island has higher ED utilization per 1,000 population, with 441 average visits compared to 411 nationally.

Table 3: Rhode Island Hospital Emergency Department Visits and Left Without Being Seen (LWBS) Measures[17]

Acute Care Hospital Name	ED Visits 2020	ED Visits 2022	% change	LWBS	Time in ED	Volume Category
Butler Hospital	2,486	2,994	20.4%	N/A	N/A	N/A
Kent County Memorial Hospital	37,560	47,356	26.1%	6%	242	High
Landmark Medical Center	24,396	24,414	0.3%	3%	220	Medium
Newport Hospital	21,204	25,880	22.1%	2%	193	Medium
Our Lady of Fatima Hospital*	18,855	20,433	8.4%	3%	194	Medium
Rhode Island Hospital	87,446	103,352	18.2%	10%	301	Very High
Roger Williams Medical Center*	22,664	22,807	0.6%	4%	207	Medium
South County Hospital Inc.	16,748	21,668	29.4%	3%	204	Medium
The Miriam Hospital	47,624	54,781	14.0%	6%	346	Very High
Westerly Hospital	14,090	18,233	29.4%	1%	112	Medium
Women and Infants Hospital of Rhode Island	16,509	22,614	37.0%	4%	205	Medium
TOTAL	**309,582**	**369,006**	**19.2%**			

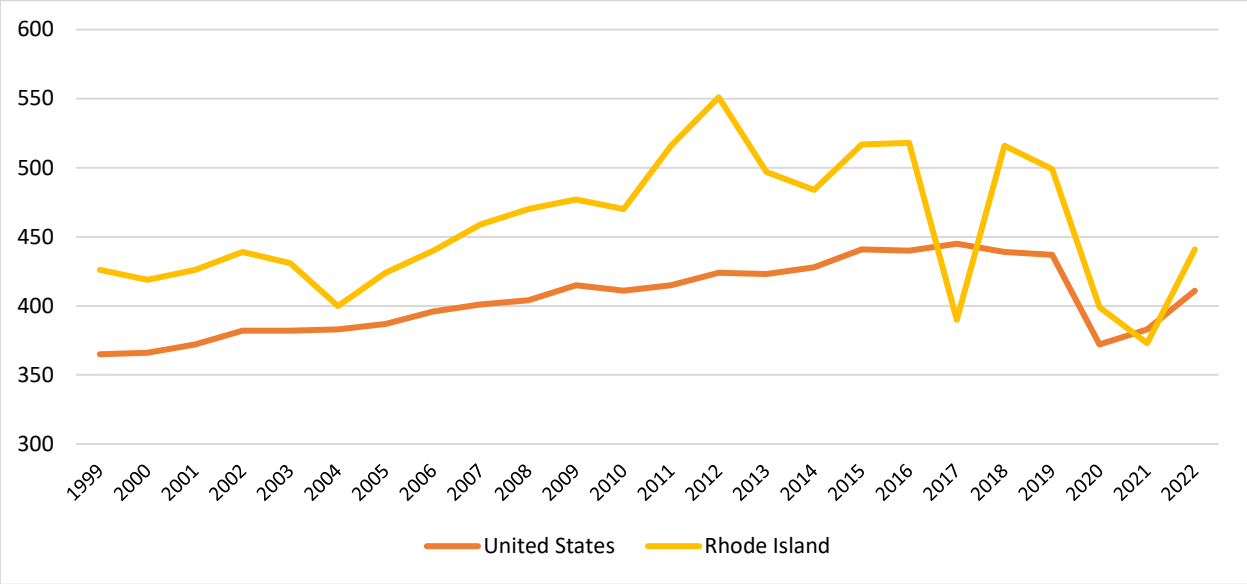
**For-Profit Hospital*

*Figure 5: ED Visits by Year (*2023 Annualized)*



[17] Rhode Island Department of Health, Emergency Department Utilization Data 2020-2022; Rhode Island Department of Health, Left Without Being Seen and Time in ED Data, Medicare.gov, April 24, 2024, for period January 1, 2022, to December 31, 2022

Figure 6: Rhode Island and National ED Utilization Rates per 1,000 Population



The "Left Without Being Seen" (LWBS) rate represents the percentage of individuals who left before being evaluated by a health care professional after signing into the emergency department. Rhode Island had a 6% LWBS rate in 2022, double the national average, indicating Rhode Island hospitals are challenged in accommodating the volume of patients seeking care. In addition, Rhode Island hospitals demonstrate higher average ED times for all volume categories compared to the national average.[18] Time in ED measures the average (median) time in minutes patients spent in the ED—from when they arrived to when they left. It doesn't include patients who died in the emergency department, left without the approval of a licensed provider, or do not have where they went after they left the ED documented in their medical records.

Table 4: Time in the ED Rhode Island and National Averages (in minutes)

Volume of ED Visits per Year	National Average	Rhode Island Average
Medium (20,000 – 39,999)	171	192
High (40,000 – 59,999)	212	242
Very High (60,000+)	194	320

Recent Rhode Island Hospital Studies

Recent studies provide additional context for hospital utilization trends in Rhode Island. HMA conducted a financial impact analysis of hospitals in 2022 for the Hospital Association of Rhode Island. The report confirmed declining utilization: "Despite federal emergency funding and pandemic flexibilities, hospitals in Rhode Island are sustaining revenue losses. The primary contributors to this loss are staffing costs, particularly for travel labor, decreased patient volume and case mix, and inflation."[19]

[18] Centers for Medicaid and Medicare Services, Care Compare Data (April 24, 2024), https://www.medicare.gov/care-compare/?providerType=Hospital.

[19] Hospital Association of Rhode Island, "Financial Impact Analysis on Hospitals in Rhode Island, 2022", March 2023, https://d3egnnukzendc6.cloudfront.net/documents/03222023HMA-Hospital-Association-of-Rhode-Island-Report-Final.pdf

The Rhode Island Foundation released an analysis in March 2024 comparing Rhode Island hospital finances and utilization to hospitals in neighboring Connecticut and Massachusetts,[20] concluding:

- Rhode Island, Connecticut, and Massachusetts experienced a 1-3% decline in age-adjusted acute hospital inpatient utilization between 2017 and 2019.
- All three states experienced a significant decline in acute care inpatient hospitalizations between 2019 and 2020 (i.e., during the COVID-19 pandemic). Rhode Island experienced the most significant decrease in utilization, with a 14% decrease in discharges compared to a 7% decrease in Connecticut and a 10% decrease in Massachusetts.
- In 2021, Rhode Island had a 5% lower inpatient acute hospital utilization rate than Connecticut and a 12% lower inpatient acute hospital utilization rate than Massachusetts.
- Rhode Island's 2021 ED visit utilization rate (28.94 visits per 100) was like Massachusetts's statewide rate and notably lower than Connecticut's (36.89 visits per 100).

Stakeholder Findings

Stakeholders generally believe the available hospital capacity meets current demand, except for behavioral health beds. They noted the 2017 closure of Pawtucket Memorial, warning that any additional closures could have catastrophic consequences. The most significant concern impacting hospital capacity is the ongoing shortage of health care workers, including primary care providers. Stakeholders say low reimbursement rates are causing Rhode Island hospitals to struggle to recruit and retain health care staff, with many professionals seeking jobs in Connecticut and Massachusetts.

This pressure to keep beds open amid workforce and reimbursement challenges is particularly acute in psychiatry, where inpatient beds are often closed due to staff shortages, exacerbating the ED boarding issue. Health equity challenges include language barriers and a lack of provider diversity that matches the population served. Although stakeholders had various ideas on addressing hospital capacity and sustainability, they agreed that resistance to change hinders necessary reforms. One stakeholder stated, "tackling workforce shortages, enhancing reimbursement rates, and ensuring equitable access to care for all residents, including the significant portion of Medicaid and Medicare. Collaboration across government departments, the health care industry, and the community is essential to forge a collective sense of purpose and enact the necessary reforms to transform Rhode Island's health care landscape into a model of excellence and sustainability." Another stakeholder referenced adopting new reimbursement models such as the CMMI AHEAD Global Budget Pilot.[21] CMS announced on October 28, 2024, that Rhode Island had been selected to participate in the third cohort of the AHEAD model, with the pre-implementation period beginning in January 2025.

AHEAD is a total cost of care (TCOC) model that drives state and regional health care transformation and multi-payer alignment to improve state health and lower costs. States manage health care quality and costs across all payers (e.g., Medicare, Medicaid, private coverage). States are also responsible for ensuring health providers deliver high-quality care, improve population health, offer greater care coordination, and advance health equity. AHEAD provides states with funding and tools to address rising health care costs and support health equity.

[20] Manatt Health, "Examination of the Financial Structure and Performance of Hospitals in Rhode Island," https://www.manatt.com/insights/white-papers/2024/examining-the-financial-structure-and-performance.
[21] Centers for Medicare and Medicaid Services, "States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model," https://www.cms.gov/priorities/innovation/innovation-models/ahead.

Key Takeaways

1. Hospital utilization rates in Rhode Island, nominal and adjusted for population, are decreasing faster than the national average. Further assessment is needed to understand the cause of this difference and its potential impact on future demands for acute care beds.
2. The average daily census (ADC) of Rhode Island hospitals is 62% of total licensed beds, indicating a misalignment of supply and demand. Further research is needed.
3. Emergency department (ED) performance in Rhode Island lags the nation, with Rhode Islanders twice as likely as the nation to leave the ED without being seen. This indicates potential ED staffing and capacity issues, overutilization tied to a lack of primary care access, and a lack of staffed acute care beds available to accommodate demand.
4. Stakeholder feedback and recent reports about Rhode Island's hospitals suggest that the state's comparatively lower hospital reimbursement is at least one underlying cause of the aforementioned trends.

Long-term Care Utilization

The Center for Medicare and Medicaid Services (CMS) has established comprehensive reporting requirements for nursing homes nationally, aiding the analysis of long-term care utilization. This data includes ownership and operational details, quality measures, and staffing data. Reporting data to CMS is required for nursing homes to participate in Medicare and Medicaid programs. The data in this report was obtained from publicly available CMS data.[22]

As of April 2024, CMS certified 74 nursing homes in Rhode Island, representing 8,276 beds (see Table 9). From 2015 to 2023, Rhode Island experienced a reduction of 9 (11%) nursing homes, significantly higher (4%) than the national average. Stakeholders noted several facilities expressing concerns about their ability to continue operating.

There is increased scrutiny in Rhode Island and nationwide about for-profit nursing home ownership, with calls for increased transparency on nursing home ownership and finances. Stakeholders echoed these concerns about Rhode Island's for-profit nursing homes. Rhode Island's nursing homes operated as for-profit entities (87%), higher than the national average (71%). None of Rhode Island's nursing homes are government-owned, compared to 6% nationally.[23]

Nationally, nursing homes heavily rely on achieving a payer mix that includes many Medicare patients to compensate for low Medicaid reimbursement rates. Enrollment in Medicare Advantage (MA) as an alternative to fee-for-service Medicare (FFS) has steadily risen. It now exceeds 50% of the Medicare-eligible population nationally and more than 60% in Rhode Island.[24] Stakeholders have noticed that the four insurers offering MA plans in Rhode Island have not increased their payments for post-acute care in nearly ten years, which means the current rates are too low to cover costs. Nursing homes are financially challenged to accept patients covered by MA and Medicaid, making it difficult for hospitals to find places to send patients who need post-acute care.

[22] Centers for Medicare and Medicaid, data.cms.gov, https://data.cms.gov/provider-data/dataset/4pq5-n9py, as of April 2024
[23] *Id.*
[24] *Supra* n. 1.

As demonstrated in Table 5 and per data reported by the nursing homes to CMS in April 2024, 83% of certified beds in Rhode Island are occupied, marking a significant drop in occupancy from 8,017 (92%) in 2015. Based on industry knowledge, sustained occupancy below 90% may imperil a skilled nursing facility's financial viability. This is of significant concern, especially as Rhode Island's population ages and will increasingly rely on long-term care services.

Table 5: Rhode Island Nursing Homes[25]

Provider	For/Non-Profit	Beds	Daily Avg Residents	Occupancy	Affiliated entity
Bristol, Bristol County					
Silver Creek Rehab & Healthcare Center	F	128	113.9	89%	Green Tree Healthcare Mgmt.
The Dawn Hill Home for Rehab & Healthcare	F	133	128	96%	Green Tree Healthcare Mgmt.
Central Falls, Providence County					
Harris Health Care Center North	F	32	27.4	86%	
West Shore Health Center	F	145	131.8	91%	Health Concepts, Ltd
Mansion Nursing and Rehab Center	F	62	52.2	84%	
Coventry, Kent County					
Alpine Nursing Home Inc.	F	60	57.7	96%	
Riverview Healthcare Community	F	190	176.1	93%	Marquis Health Services
Respiratory and Rehab Center	F	210	132.9	63%	Genesis Healthcare
Cranston, Providence County					
Cedar Crest Nursing Centre Inc.	F	156	147.5	95%	
Cra-Mar Meadows	F	41	34.9	85%	
Scandinavian Home Inc.	N	74	60.7	82%	
Cumberland, Providence County					
Mount St. Rita Health Centre	N	98	70.5	72%	Covenant Health
Greenville, Providence County					
Stillwater Assisted Living and Skilled Nursing Community	F	80	71.1	89%	Eden Healthcare
Greenville Skilled Nursing and Rehab	F.	131	81.5	62%	Genesis Healthcare
East Greenwich, Kent					
Saint Elizabeth Home	N	168	151.5	90%	
East Providence, Providence County					
Hattie Ide Chaffee Home	N	60	53.3	89%	
Waterview Villa Rehabilitation and Health Care Center	F	132	103.5	78%	Athena Healthcare Systems
Tockwotton on the Waterfront	N	52	51.4	99%	
Harris Health Center LLC	F	31	28	90%	
Linn Health and Rehabilitation	N	84	68	81%	
Eastgate Nursing & Rehab Center	F	60	58.5	98%	Health Concepts, Ltd.

[25] *Supra* n. 23.

Orchard View Manor	F	166	122.8	74%	Athena Healthcare Systems
Evergreen House Health Center	F	160	122.4	77%	Life Care Centers of America
Johnston, Providence County					
Cherry Hill Manor	F	171	160.2	94%	Life Care Centers of America
Morgan Health Center	F	120	108.5	90%	Marquis Health Services
Manville, Providence County					
Holiday Retirement Home Inc.	F	170	143.4	84%	
Middletown, Newport County					
Grand Islander Center	F	146	117	80%	Genesis Healthcare
Royal Middletown Nursing Center	F	50	34.2	68%	Royal Health Group
John Clarke Retirement Center	N	60	53.3	89%	
Newport, Newport County					
St. Clare Home	N	50	48	96%	
Heatherwood Rehabilitation & Health Care Center	F	114	94.9	83%	Athena Healthcare Systems
Village House Nursing & Rehab Center	F	95	82.6	87%	Health Concepts, Ltd.
North Kingston, Washington County					
Roberts Health Centre Inc.	F	66	62.2	94%	
Bayview Rehabilitation and Healthcare Center	F	120	107.7	90%	Marquis Health Services
South County Nursing & Rehabilitation Center	F	120	95.8	80%	Eden Healthcare
North Providence, Providence County					
Golden Crest Nursing Centre	F	152	143.2	94%	
Lincolnwood Rehabilitation and Healthcare Center	F	200	170.9	85%	Marquis Health Services
North Smithfield, Providence County					
St Antoine Residence	N	260	172.6	66%	
Pascoag, Providence County					
Crystal Lake Rehab and Care Center	F	71	61.7	87%	
Bayberry Commons	F	110	93.5	85%	
Overlook Nursing and Rehab Center	F	100	81.3	81%	Eden Healthcare
Pawtucket, Providence County					
Oak Hill Health & Rehab Center	F	129	122.3	95%	Centers Health Care
Jeanne Jugan Residence	N	49	38.8	79%	Little Sisters of the Poor
Pawtucket Falls Healthcare Center	F	154	71.7	47%	CCH Healthcare
Providence, Providence County					
Berkshire Place	F	220	192.5	88%	Green Tree Healthcare Mgmt.
Summit Commons Rehab and Health Care Center	F	165	96.8	59%	Athena Healthcare Systems
Bethany Home of Rhode Island	N	33	28.9	88%	
Steere House Nursing and Rehabilitation Center	N	120	107.1	89%	
Elmhurst Rehabilitation & Healthcare Center	F	206	149.7	73%	Marquis Health Services

Bannister Center for Rehabilitation and Health Care	F	161	117.2	73%	Centers Health Care
Elmwood Nursing and Rehab Center	F	70	61.6	88%	Health Concepts, Ltd.
Smithfield, Providence County					
Heritage Hills Nursing & Rehab Center	F	100	81.2	81%	Marquis Health Services
Hebert Nursing Home	F	133	107.1	81%	
South Kingstown, Washington County					
Elderwood of Scallop Shell	F	80	56.8	71%	Elderwood
Warren, Bristol County					
Grace Barker Nursing Center	F	86	84.1	98%	
Warren Skilled Nursing and Rehab	F	63	46.2	73%	Genesis Healthcare
Crestwood Nursing & Rehabilitation	F	76	59	78%	
Warwick, Kent County					
West Shore Health Center	F	145	131.8	91%	Health Concepts, Ltd.
Greenwood Center	F	130	108.5	83%	Genesis Healthcare
Kent Regency Center	F	153	146.5	96%	Genesis Healthcare
Sunny View Nursing Home Rehab	F	57	53.4	94%	Eden Healthcare
Avalon Nursing Home Rehab	F	31	30.6	99%	
Brentwood Nursing Home	F	96	87.3	91%	Eden Healthcare
West Kingston, Washington County					
Kingston Center for Rehab & Health Care	F	55	44.5	81%	Centers Health Care
South Kingstown Nursing and Rehab	F	96	94.2	98%	Health Concepts, Ltd.
West Warwick, Kent County					
West View Nursing & Rehab Center	F	120	90.4	75%	Eden Healthcare
Westerly, Washington					
Royal of Westerly Nursing Center	F	66	60.4	92%	Royal Health Group
Apple Rehab Clipper	F	60	50.5	84%	Apple Rehab
Westerly Health Center	F	106	107.7	102%	Marquis Health Serv.
Woonsocket, Providence					
Oakland Grove Health Center	F	178	113.5	64%	Athena Healthcare
Woonsocket Health Centre	F	150	124.5	83%	
Friendly Home Inc.	F	126	117.7	93%	
Trinity Health and Rehab Center	F	185	131.3	71%	
TOTAL		**8,227**	**6,790.4**	**83%**	

Stakeholder Findings

Stakeholders reported that many long-term care beds are not occupied due to significant staffing challenges, as demonstrated by this analysis.

Many stakeholders expressed concern that federal and state staffing mandates will place further financial strain on nursing homes, leading to fewer available staffed beds and more facility closures. Due to the severe labor crisis impacting Rhode Island's nursing homes, Governor McKee declared a nursing home emergency on December 29, 2023, suspending penalties for nursing homes not meeting minimum staffing standards. The declaration cited workforce ("Rhode Island nursing homes have lost 20% of their workforce since 2020") and financial challenges ("since 2020, six Rhode Island nursing homes have closed, and three Rhode Island nursing homes have been placed into receivership in the last several

months") as factors necessitating the declaration.[26] Nursing homes were impacted by longstanding workforce shortages that predated the pandemic for many years. The pandemic exacerbated these problems, and workforce numbers have rebounded from the pandemic impact more slowly in nursing homes than in other health care sectors, such as hospitals and ambulatory care.

Accessibility issues in health care include language barriers and affordability in nursing homes. There are limited beds available for residents with complex care needs, such as those with traumatic brain injuries (TBI), mental health issues, substance use disorders, bariatric care requirements, and pediatric long-term care, due to staffing shortages and training requirements. A stakeholder offered that Rhode Island recently launched an initiative to provide add-on rates to encourage the acceptance of patients and residents with behavioral health or substance use needs. However, no providers took advantage of the opportunity, possibly because of the associated administrative burden. Aside from this initiative, the state has limited investments in the long-term care sector. Additionally, the impact of COVID-19 has been significant, with six nursing homes closing during the pandemic, three recently entering receivership, and more publicly discussing closures.

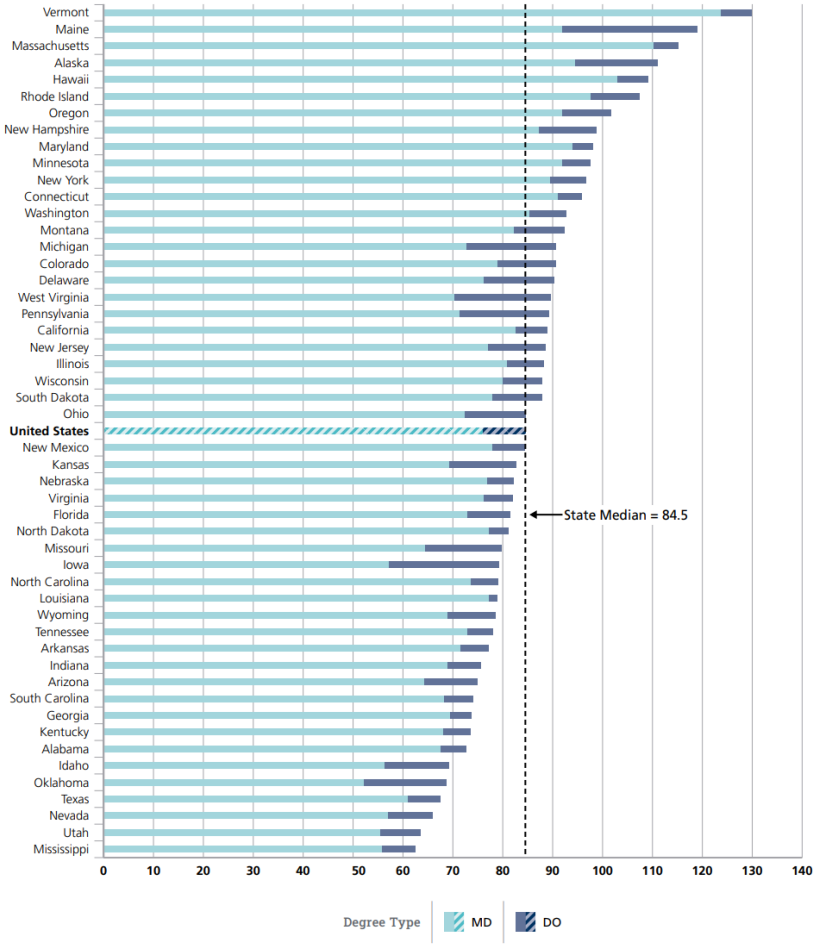
Key Takeaways

1. Nursing home closures and the overall reduction in nursing home occupancy in Rhode Island since 2015 exceeded the national rate despite a higher percentage of the population over 65.
2. Rhode Island's percentage of nursing homes operated as for-profit entities (87%) is higher than the national average (71%).
3. In Rhode Island, more than 60% of the Medicare population is enrolled in Medicare Advantage (MA) plans.[27] According to key informant interviews, Rhode Island's main MA plans have not adjusted post-acute care rates in nearly ten years, significantly trailing behind fee-for-service rates. This disparity and insufficient Medicaid reimbursement may contribute to the lack of post-acute beds for patients discharged from acute hospitals.

[26] R.I. Executive Order 23-11, December 29, 2023, http://governor.ri.gov/executive-orders/executive-order-23-11.
[27] *Supra* n. 1.

Primary Care Provider Sufficiency

Figure 7: Active Patient Care Primary Care Physicians per 100,000 Population by Degree Type, 2020



HMA utilized the CMS definition of a primary care provider to analyze primary care sufficiency. Primary care includes family practice (including geriatrics), internal medicine (including geriatrics), obstetrics/gynecology, and pediatrics.[28] HMA used the Rhode Island Department of Health database of licensed physicians. The location of the practice in the analysis is the address in the database.

Stakeholders, news reports,[29] and state agencies report on the difficulty residents of Rhode Island experience in identifying providers for primary care services. These challenges reflect the national supply shortage of primary care providers necessary to meet current and future demand.[30]

Although there is some concern regarding primary care access in Rhode Island, the state performs well in primary care supply compared to the national average. Rhode Island is ranked fifth in the nation for primary care physicians per 100,000, with 107.5 per the American Association of Medical Colleges analysis based on 2020 data from the American Medical Association (Figure 7).[31] This is consistent with HMA's analysis utilizing the Rhode Island licensure database accessed in 2024, which demonstrated 106.51 primary care physicians per 100,000 population.

While Rhode Island's overall primary care provider numbers are favorable, an important question remains: Are certain areas disproportionately underserved? Table 6 and Figure 8 highlight the uneven distribution of primary care physicians across Rhode Island. Notably, Northeast Rhode Island (Central Falls) and Providence County (Southeast) have significantly fewer primary care physicians per 100,000 population than other regions. Conversely, Providence City has a disproportionately higher

[28] Centers for Medicare and Medicaid Services, "Glossary," https://www.cms.gov/glossary?items_per_page=30&page=26&viewmode=grid.
[29] Russo, A, "Finding a primary care doctor in Rhode Island is getting more difficult. Here's why," The Providence Journal (February 8, 2023), https://www.providencejournal.com/story/news/healthcare/2023/02/08/primary-care-doctor-shortage-in-ri/69843973007.
[30] Association of American Medical Colleges, "The Complexities of Physician Supply and Demand: Projections From 2021 to 2036," March 2024, https://www.aamc.org/media/75236/download?attachment.
[31] Association of American Medical Colleges, "State Physician Workforce Data Report (2021)," https://www.aamc.org/data-reports/workforce/report/state-physician-workforce-data-report.

concentration of primary care physicians, likely due to the presence of the medical school and affiliated academic medical centers.

Table 6: Number of Primary Care Physicians

Census Tract	License Number Count	Population	Primary Care License/100,000 population
Central Rhode Island-Kent County-Warwick City	228	169,290	134.68
Northeast Rhode Island-Providence County-Pawtucket & Central Falls Cities	10	189,870	5.27
Northwest Rhode Island-Providence County (West & Central)-Woonsocket City	53	147,890	35.84
Providence City	761	188,840	402.99
Providence County (Southeast)- Cranston & East Providence Cities	4	129,620	3.09
South Rhode Island-Washington County	78	130,270	59.88
Southeast Rhode Island-Newport & Bristol Counties-Newport City	29	136,170	21.30
TOTAL	**1163**	**1,091,950**	**106.51**

Stakeholder Findings

Stakeholders reported hearing many anecdotes from Rhode Islanders about the difficulty of finding a primary care provider available for an appointment in a reasonable timeframe. Stakeholders noted that Rhode Island trains primary care physicians through residency programs that should serve as a feeder for primary care providers. However, many residents leave the state to practice due to high costs and low reimbursement. A recently published article in Rhode Island Medical Journal confirms this concern: "Of the 106 graduates from primary care residencies in Rhode Island in the academic year 2002–23 (sic), only 15 (14%) planned to provide primary care in Rhode Island. Similarly, of the 144 NP and PA graduates in primary care programs, only 48 (33%) planned to provide primary care in the state."[32]

Stakeholders reported that medical practices cannot fill open positions, and providers are aging, with a large cohort of over 55 years. Brown University School of Medicine is a natural feeder to provide local providers; however, many train in Rhode Island and then leave. Practices in Massachusetts are more profitable. A plaintiff-friendly malpractice environment leads to higher malpractice costs. New providers generally seek better work/life balance and wish to work fewer hours than the preceding generation. Higher costs and lower reimbursement lead to physicians leaving the state. The current physician population needs to be more diverse to reflect the populations served across the state.

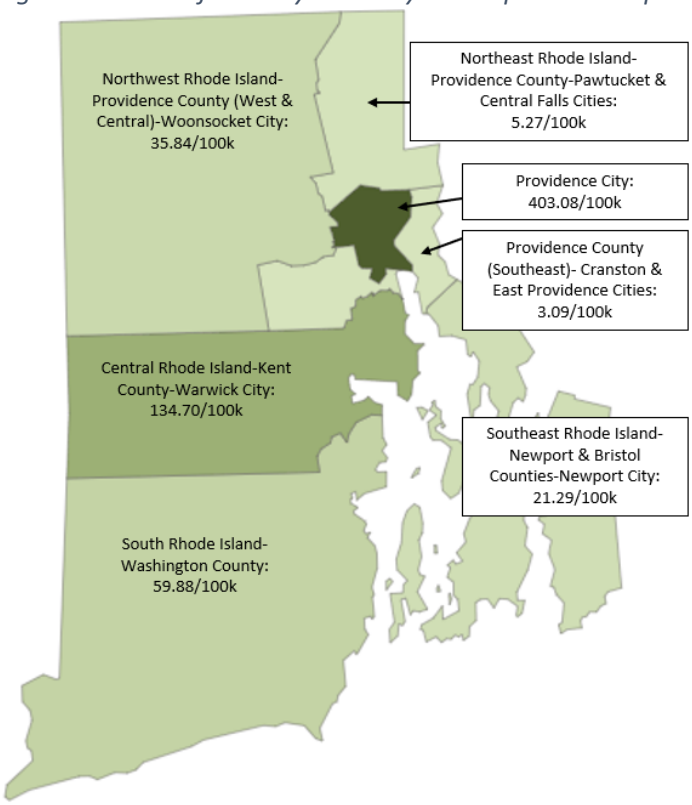
Given Rhode Island's high density of academic programs, where physician faculty often practice part-time, and its concentration of industries employing physicians in non-clinical roles, it is essential to clarify whether the reported data accurately reflects the primary care workforce actively engaged in

[32] Borkan J, Coppa D, Flanagan P, Hurwitz D, Saal A, Bowes Y, Nicolella E, Hollmann P, "Primary Care Access for All: A Roadmap for Addressing the Primary Care Crisis in Rhode Island," R I Med J (2013). 2024 Apr 1;107(4):40-44. PMID: 38536140.

patient care. This concentration of academic programs is reflected in the high number of PCPs per 100,000 residents in Providence City.

Stakeholders shared anecdotes of individuals having difficulty finding a PCP. However, no publicly available data exists on which providers are open to accepting new patients and having appointments in a reasonable timeframe. This makes it difficult to assess the true nature of perceived primary care provider shortages. In addition, follow-up sampling practices in each geography and inquiring about the time available for an appointment could help determine the practice's availability to accommodate new patients and provide further actionable information on the magnitude and demographics of primary care access challenges.

Figure 8: Count of Primary Care Physicians per 100k Population



Key Takeaways

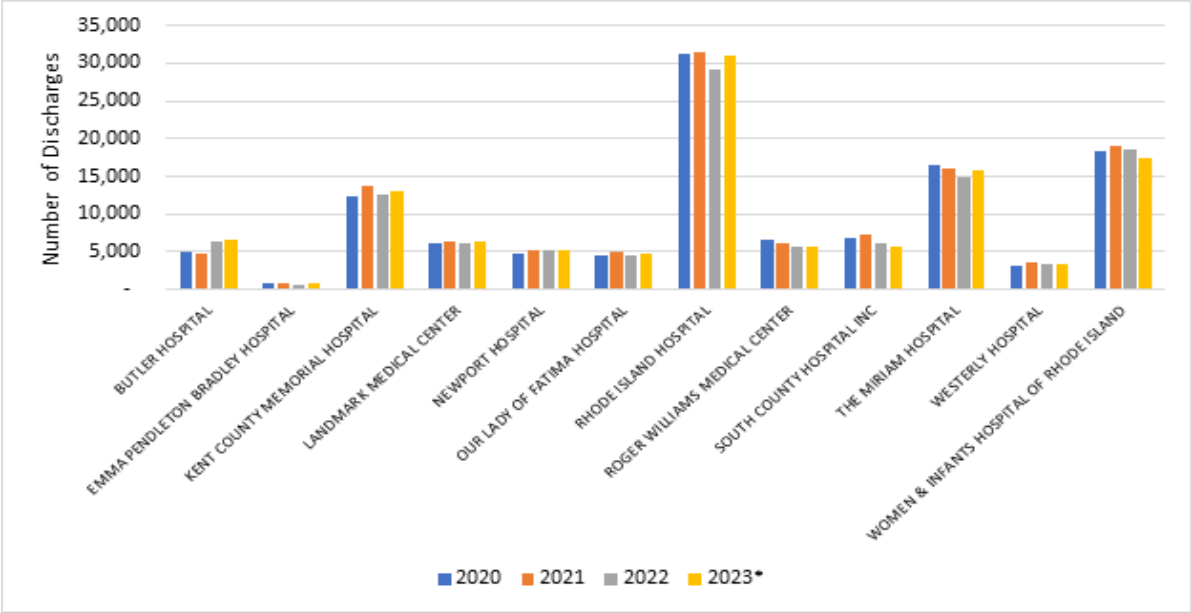
1. Compared to other states, Rhode Island has among the highest number of primary care providers per capita. Recent reports and stakeholder feedback suggest this information may lead to inaccurate conclusions about the actual availability of providers to patients seeking a primary care appointment. Further study is necessary.
2. While Rhode Island ranks favorably among the nation's primary care physicians (PCPs), they are not evenly distributed throughout the state, creating pockets of lower PCP sufficiency.

Appendix A: Stakeholder Interviewee List

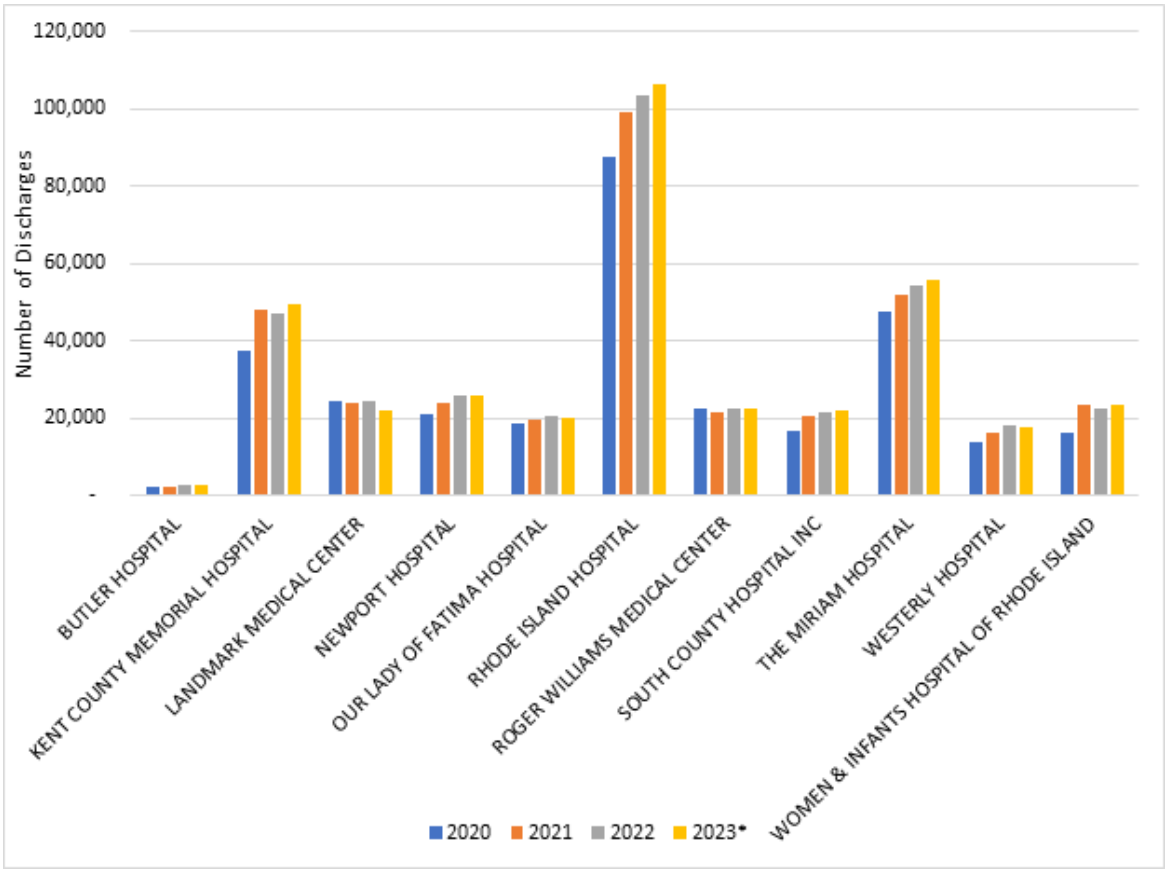
Interviewee	Title	Affiliation
Teresa Paiva Weed	Chief Executive Officer (CEO)	Hospital Association of Rhode Island
Lynn Blais	President	United Nurses and Allied Professionals
Jeffrey Borkan	Assistant Dean for Primary Care-Population Health, Professor of Family Medicine, Professor of Medical Science	Alpert Medical School, Brown University
Al Charbonneau	Executive Director	Rhode Island Business Group on Health
Cynthia Danner	Senior Vice President (SVP) and Chief Nursing Officer (CNO)	Rhode Island Hospital and Hasbro Children's Hospital
Seema Dixit	Deputy Director	Rhode Island Department of Health
Howard Dulude	Vice President	Hospital Association of Rhode Island
Kathleen Heren	Long-Term Care Ombudsman	Office of the Rhode Island State Long Term Care Ombudsman
Debra Hurwitz	Executive Director	Care Transformation Collaborative Rhode Island
Lori Light	Long Term Care Ombudsman and Volunteer Training Coordinator	Office of the Rhode Island State Long Term Care Ombudsman
Jesse Martin	Executive Vice President (EVP)	New England Health Care Employees Union District 1199 (SEIU 1199 NE)
James Nyberg	Executive Director	LeadingAge Rhode Island
Sandra Powell	Deputy Director of Operations	Rhode Island Department of Health
Louis Cerbo	Interim Director	Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals
Amanda Stefancyk Oberlies	Chief Executive Officer (CEO) and Chief Nursing Officer (CNO)	Organization of Nurse Leaders
Stacy Paterno	Executive Vice President	Rhode Island Medical Society
Lisa Tomasso	Senior Vice President	Hospital Association of Rhode Island
Utpala Bandy	Interim Director	Rhode Island Department of Health
Ashley Waddell	Senior Director of Leadership Development and Government Affairs, and Associate Chief Nursing Officer	Organization of Nurse Leaders

Appendix B: Hospitals

*Inpatient Discharges by Hospital (*2023 Annualized)*

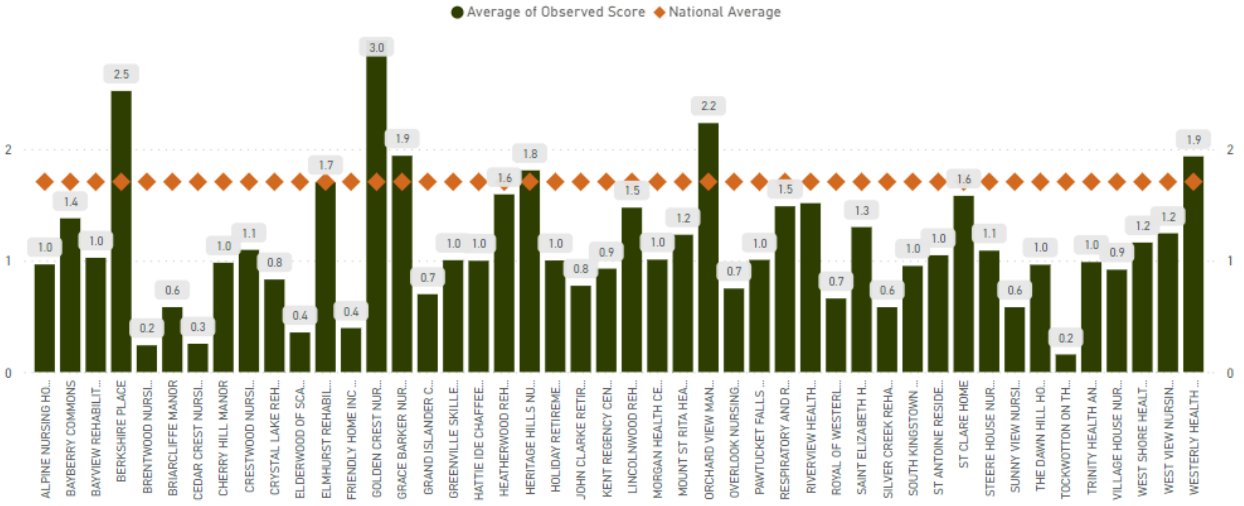


*Counts of ED Visits by Hospital and Year (*2023 Annualized)*

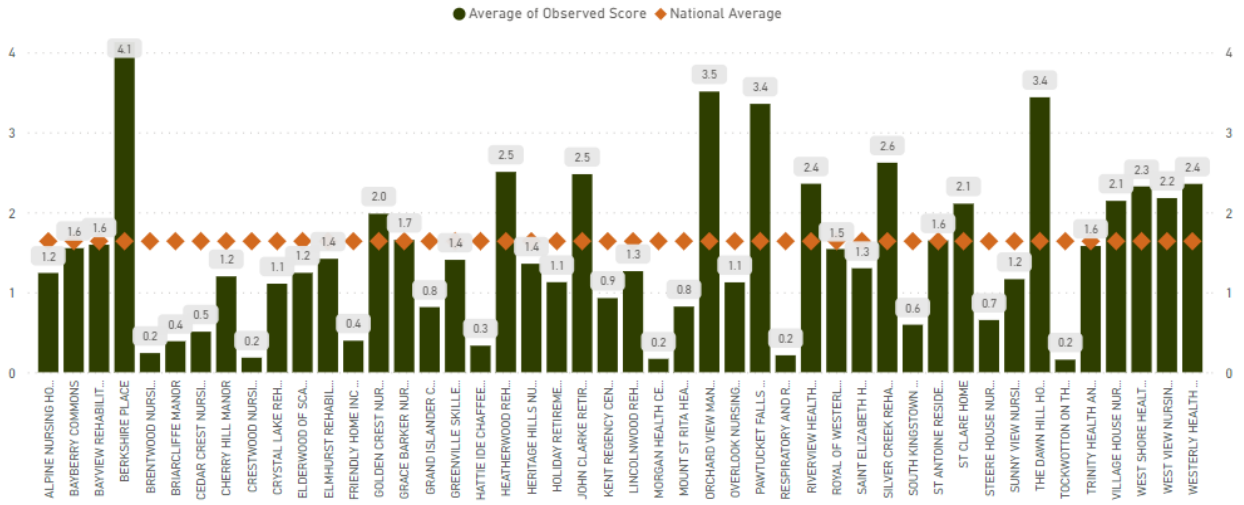


Appendix C: Nursing Homes

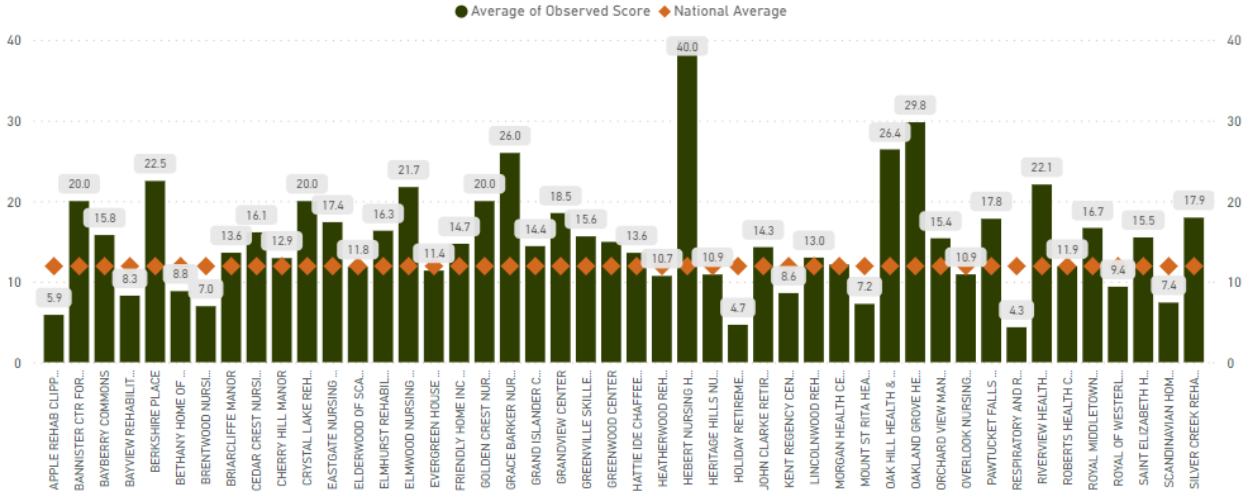
Number of hospitalizations per 1000 long-stay resident days



Number of outpatient emergency department visits per 1000 long-stay resident days



Percentage of short-stay residents who had an outpatient emergency department visit



Percentage of short-stay residents who were rehospitalized after a nursing home admission