PROPOSAL

# Improving Rhode Island's Health Care Regulatory Agencies

October 2026

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# I. Introduction

Every Rhode Islander deserves access to affordable, high-quality, evidence-based health care. True access to health care goes beyond just having insurance coverage. It requires timely access to care from qualified health care professionals and the ability to secure an appointment with the appropriate providers. It also includes access to the necessary resources and environments that promote good health – such as quality education, safe housing, economic stability, and a supportive community. Without access to the conditions that support good health, a society cannot thrive, its economy cannot grow, and individuals cannot reach their full potential. Poor health not only takes a direct toll on people's lives, but it also forces them into higher-acuity and higher-cost health care settings, fueling a pernicious cycle that strains families, communities, and resources alike.

Government has a fundamental responsibility to ensure the conditions for good health are met for all residents, regardless of income or health status. To fulfill that responsibility, Rhode Island must be able to **(1) understand the needs and gaps that exist across the state, (2) identify and correct the areas where state action is lacking, and (3) proactively anticipate and prepare for future health care needs**. The State must develop strategies focused on the determinants of health that ensure the right resources exist to meet the evolving and expanding needs of all Rhode Islanders. This requires careful planning and investment.

In exercising its statutory authority within the health care arena, the Office of the Attorney General (RIAG) has seen a pattern of ineffective and miscalculated regulatory processes that have left Rhode Island's health care system in a state of continuous crisis. Rather than engage in proactive, data-driven processes, health planning in Rhode Island is performed on a transaction-by-transaction basis, with little consideration of the system as a whole. These failures are systemic, not attributable to any one source.

Today, Rhode Island's health care system is fragmented, underfunded, and suffers from a lack of strategic planning. It is managed by a regulatory system that is overly siloed and focused primarily on reacting to developments rather than planning for the future. Regulatory oversight is divided across multiple agencies with overlapping and unclear responsibilities. Compounding these issues, the state government lacks institutional knowledge and expertise in health system data collection and analytics, allowing unseen crises to

materialize. This leaves Rhode Island's health regulators ill-prepared to identify and understand the root causes of the crises, and unable to implement targeted, effective policy solutions. Without urgent reform, the State risks continued systemic failures that will undermine the health and well-being of Rhode Islanders.

While Rhode Island's regulators have attempted to address some health system shortfalls over the years, these attempts have failed to produce lasting results due to the absence of sustained action, a lack of cohesive and unified leadership, and inattentiveness to the infrastructure necessary to drive sustainable reform. With federal financial support for health care waning, state regulators can no longer afford to play a passive regulatory role with the expectation that the federal government, or market participants themselves, will sort things out. More proactive, coordinated regulatory leadership is needed to build a sustainable health care system. States across the country with effective health system oversight bodies have established strong, independent agencies charged with monitoring health care financing, evaluating system performance, and implementing timely, targeted interventions aligned with population health needs and strategic priorities. Rhode Island must follow this proven model – drawing on best practices from other leading states – to ensure our health care system is accountable, data-driven, and responsive to the needs of Rhode Islanders.

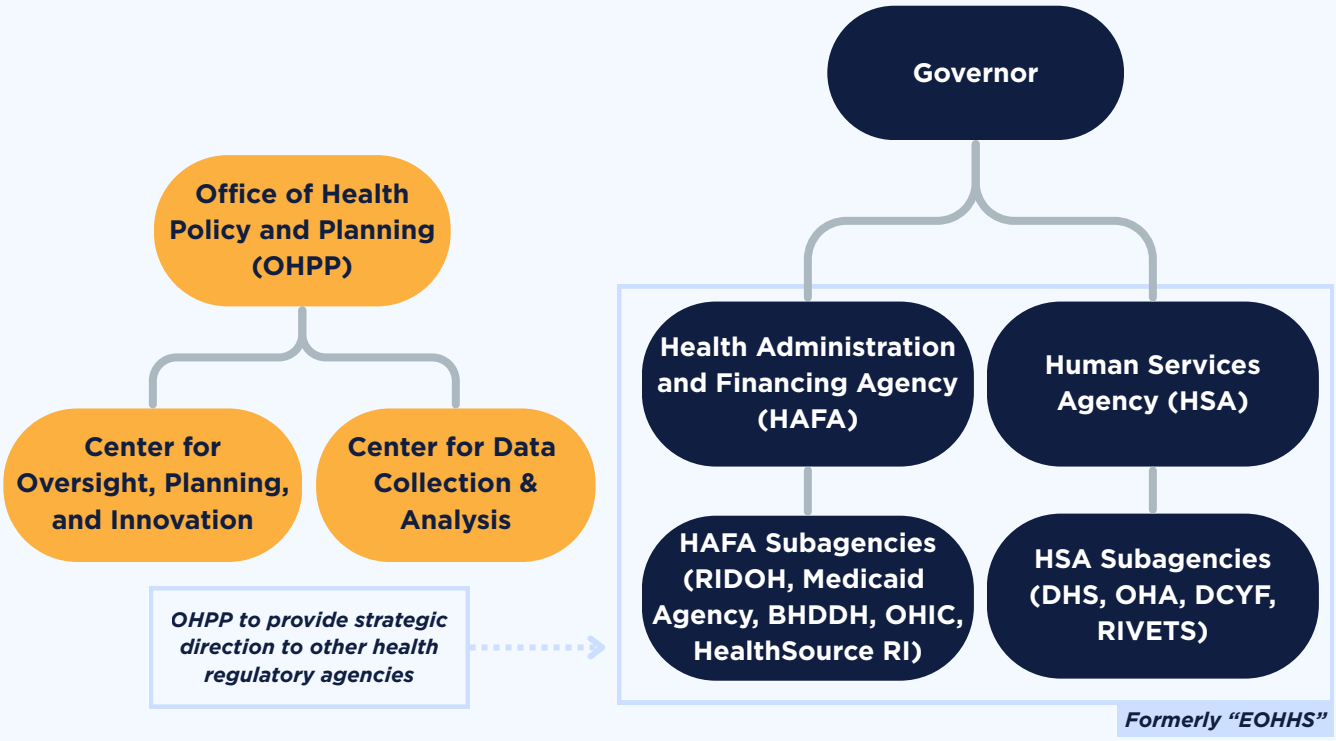
To promote effective and sustainable health regulation – and to prevent future crises – this Proposal recommends two essential reforms:

**(1) Establish the Office of Health Policy and Planning (OHPP)** as a new, independent agency designed to enhance health data analysis and health policy development in Rhode Island and lead the creation of long-term policies that put the State's health care system on a path to sustainability; and

**(2) Reorganize the Executive Office of Health and Human Services (EOHHS)** to centralize all areas of health care regulation under two reconstituted cabinet-level agencies: the Health Administration and Financing Agency (HAFA) and the Human Services Agency (HSA). Operating alongside the newly established OHPP, these agencies would enhance accountability, streamline oversight, and ensure a more responsive approach to managing Rhode Island's health care system.

This Proposal outlines these recommended reforms and lays the groundwork for future stakeholder engagement, policy development and legislative action to enshrine effective reforms into law and ensure lasting impact.

**Figure 1. Proposed Agency Restructure**




## A. Key Challenges in Rhode Island

The agency restructuring proposed herein is rooted in the core principle that the primary responsibility of an effective government is to understand and prioritize the health needs of its population. With that in mind, we begin by discussing Rhode Island's performance on key health system metrics and health outcomes, and by identifying the problems and systemic challenges within the State's current regulatory framework.

### 1. Health Outcomes and Affordability

Rhode Island's health care system provides care for approximately 1.1 million Rhode Islanders each year. Based on nationwide comparisons, Rhode Island ranks favorably on many public health measures, such as childhood and adult vaccine adoption, infant mortality, and adult cancer screening, but its performance lags other New England states and national averages on other leading indicators – including prevention and treatment, avoidable hospital use and costs, and a range of health disparity measures:[1]

1. U.S. Health Care Rankings by State 2025 | Commonwealth Fund

- **Working age, commercially insured adults in Rhode Island are hospitalized at rates that are higher than the national average**, and patients in skilled nursing facilities (SNFs) are significantly more likely to be readmitted to the hospital. When hospitalized, Rhode Islanders also face a higher risk of central line-associated bloodstream infections than the national average.[2]
- **Rhode Islanders' perceptions of their own community health and well-being are in decline** – driven by the lack of affordable housing, rising cost of living, persistent food insecurity, and a lack of stable job opportunities.[3]
- **Asthma prevalence among adult Rhode Islanders is consistently higher than the national average**, and among children, the rate of hospitalization/emergency department visits for asthma has increased.[4]
- **Based on 2023 data, roughly 13% of diabetic adults in Rhode Island never receive an annual hemoglobin A1c test.** Poorly managed diabetes contributes to a host of high-acuity diseases, such as heart disease, nerve and kidney damage, foot ulcers, and glaucoma.[5]
- In Rhode Island, **23% of children who need behavioral health care go without it**.[6]
- **A staggeringly high proportion (21%) of Rhode Island nursing home residents receive antipsychotic medication**, a marker for potential overuse of sedatives for non-clinical reasons like facility/staff convenience.[7]
- **Low-income and historically marginalized communities, such as Black, Latino, and LGBTQ populations, experience greater unmet behavioral health treatment needs than the general population**,[8] and as discussed below, they also face disproportionate barriers related to coverage and affordability, which hinders access to care and contributes to poorer overall health outcomes compared to their White counterparts.

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2. https://interactives.commonwealthfund.org/2025/state-scorecard/Rhode_Island.pdf
3. 2024 RI Life Index shows Rhode Islanders perceive continuing challenges in housing, cost of living and food security | School of Public Health | Brown University
4. Asthma Data | Department of Health
5. https://interactives.commonwealthfund.org/2025/state-scorecard/Rhode_Island.pdf; https://www.heart.org/en/health-topics/diabetes/diabetes-complications-and-risks.
6. https://interactives.commonwealthfund.org/2025/state-scorecard/Rhode_Island.pdf.
7. https://interactives.commonwealthfund.org/2025/state-scorecard/Rhode_Island.pdf; Why Too Many Psychotropic Medications in Nursing Facilities?
8. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2024-05/Statewide%20Community%20Needs%20Assessment_03.22.2024.pdf, at 7.

Ensuring the long-term health of Rhode Islanders requires a sustained and unwavering focus on addressing and reversing these trends.

As is true in many states, health care is Rhode Island's largest employment sector, with over 86,000 people employed in clinical and non-clinical roles.[9] While Rhode Islanders generally pay less for care than residents of neighboring states, overall health care spending remains a significant policy concern. Based on data from 2024, total health care spending in Rhode Island was over $10.25 billion, or more than $10,900 per person.[10] 33.9% of spending was attributable to Medicare, 33.6% to Medicaid, and 26.4% to commercial insurance.[11] Roughly half of all health care spending in Rhode Island arises from hospital care and long-term care.[12] Rhode Islanders are expected to face growing affordability challenges as federal Medicaid and Affordable Care Act (ACA) funding declines in the coming years. This will create significant compliance and funding burdens for the state,[13] increase the number of uninsured residents,[14] and intensify pressure on health care through rising levels of uncompensated care.[15] Thoughtful, long-term cost control must remain a top priority.

**2. Systemic Challenges**

Despite the dedication of Rhode Island's health care providers and public servants, the State's health care system continues to fail its residents. This failure is neither a new nor uniquely Rhode Island problem—leading stakeholders have acknowledged these shortcomings for years, and calls for change have even come from within the regulatory community. In 2024, the Health Care System Planning (HCSP) Cabinet published a detailed report identifying a similar set of challenges.[16] Despite the HCSP Cabinet's efforts to catalog issues and propose recommendations, the report did not establish any legally binding mandates, and meaningful reform has yet to occur. In many ways, conditions have deteriorated further since the Cabinet report was issued.[17]

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9. Rhode Island Department of Labor and Training, Nonfarm Payrolls (May 2025), https://dlt.ri.gov/labor-market-information/data-center/current-employment-statistics-ces
10. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2026-05/OHIC%20Cost%20Trends%20Report_Final%2005.18.2026.pdf
11. *Id*.
12. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2025-05/OHIC%20Cost%20Trends%20Report_final%2005.12.2025.pdf
13. Federal Compliance Advisory Group Report_vFinal_10302025.pdf
14. How Will the 2025 Reconciliation Law Affect the Uninsured Rate in Each State? | KFF
15. Robert Wood Johnson Foundation, "Reconciliation Bill Effects on States' Health Care Spending and Uncompensated Care," June 13, 2025. https://www.rwjf.org/en/insights/our-research/2025/06/reconciliation-bill-effects-on-states-healthcare-spending-and-uncompensated-care.html.
16. Health Care System Planning Foundational Report - December 2024.pdf
17. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2026-05/HCSP%20Annual%20Report%20-%20May%202026%20.pdf

Several examples illustrate the key problems identified with the current system:

- **Acute Patient Access Challenges Due to Workforce Shortages.** Like other states across the country, Rhode Island is experiencing an acute workforce shortage that hinders the system's ability to provide high-quality care for all Rhode Islanders.[18] The shortage has been particularly acute in primary care, long-term care facilities, behavioral health, and hospitals. Many patients cannot find a primary care provider (PCP) that accepts new patients, or patients face wait times of several months before their next appointment. Researchers report that there are less than 700 practicing PCPs in the entire state, and Rhode Island requires an additional 300 PCPs (a nearly 50% increase from current levels) to meet its needs.[19] Workforce shortages and the lack of primary care access take a toll on other parts of the health care system. A recent study found that hospitals in Rhode Island have the highest average occupancy rates in the country due to a reduction in staffed beds.[20] High hospital occupancy rates[21] result in emergency department overcrowding, delays in care, staff burnout, and poor health outcomes.[22] In the long-term care context, nursing homes have lost thousands of employees just in the past five years, prompting resident safety concerns.[23] As it relates to behavioral health, a March 2025 report by National Alliance on Mental Illness found that over 390,000 Rhode Islanders live in communities without a sufficient number of mental health professionals.[24] These provider shortages create access challenges for Rhode Islanders, which are even more acute for low-income residents.

18. Health Care System Planning Foundational Report - December 2024.pdf at 219-20; Hundreds more physicians needed to address RI primary care shortage, experts say | WPRI.com
19. https://www.wpri.com/target-12/hundreds-more-physicians-needed-to-address-ri-primary-care-shortage-experts-say/
20. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2830387;
21. The hospital bed occupancy rate reflects a hospital's daily census divided by the number of staffed beds, so when the number of staffed beds declines, its occupancy rate increases.
22. A. Guttmann, M.J. Schull, M.J. Vermeulen, T.A. Stukel. Association between waiting times and short term mortality and hospital admission after departure from emergency department: population based cohort study from Ontario, Canada. British Medical Journal, 342 (2011), p. d2983; T. S, E. Rivers. Emergency department overcrowding in the United States: an emerging threat to patient safety and public health. Emergency Medicine Journal, 20 (2003), pp. 402-405; N.R. Hoot, D. Aronsky. Systematic Review of Emergency Department Crowding: Causes, Effects, and Solutions. Annals of Emergency Medicine, 52 (2) (2008), pp. 126-136
23. https://governor.ri.gov/executive-orders/executive-order-23-11
24. https://www.nami.org/wp-content/uploads/2025/05/RhodeIsland-GRPA-Data-Sheet-8.5-x-11-wide.pdf

- **Financial Strains on our Health Care System.** Many health care facilities are facing dire financial conditions—conditions that are likely to be aggravated by federal funding cuts to Medicaid and ACA subsidies. In the course of reviewing transactions under the Hospital Conversions Act, the Office of the Attorney General has observed hospitals operating at low or negative margins, at significant risk of financial shock and unable to invest in their service lines.[25] This is driven by high supply and overhead costs, elevated staffing costs, and substantial debt servicing burdens (especially among private equity-owned facilities). High-cost facilities struggle to perform financially under current payment rates,[26] and payment rate disparities with neighboring states pose a barrier to recruitment and retention.[27] Ongoing federal funding cuts will only exacerbate these risks.[28] Despite these financial challenges, layoffs, and closures of Rhode Island health care institutions,[29] the state has not yet implemented systemic reforms to address the worsening outlook for its health care system.
- **Consolidation and the Role of Private Equity.** Rhode Island's health care market is more concentrated than ever,[30] with hospital-affiliated and corporatized medical practices now the dominant form of practice. The

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25. Most recently, in the Attorney General's 2024 Hospital Conversions Act Decision regarding the proposed sale of CharterCARE Health Partners, comprised of two safety net hospitals, Roger Williams Medical Center and Our Lady of Fatima Hospital, the Attorney General's financial expert, Veralon, found that "[c]onsideration of CharterCARE's historical and current performance indicates a system that is in significant financial distress and incapable of generating revenues sufficient to cover its expenses…" https://www.riag.ri.gov/healthcare
26. https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/ (observing that in 2024, Rhode Island had the lowest Medicaid-to-Medicare fee for service (FFS) payment ratio in the country at 52%); https://assets.rifoundation.org/documents/RIF-Hospital-and-Health-Systems-Study_post_updated-4.18.24.pdf?_gl=1*8l1abd*_ga*MTQzOTUyNDUzLjE3NTA2NDE0NDk.*_ga_H77MVBSLCR*czE3NTUxNzYxNzgkbzQkZzEkdDE3NTUxNzcwMjkkajYwJGwwJGgxNTkyMzU5NzE3 at 7 (observing, based on 2021 data, that 2021 data, Medicare FFS payment per inpatient discharge paid to Rhode Island hospitals was $14,324, compared to $16,381 in Massachusetts and $16,951 in Connecticut).
27. *Id*. at 11.
28. Many of these federal changes to health care were included in H.R.1 (2025), passed by Congress on July 4, 2025. https://www.congress.gov/bill/119th-congress/house-bill/1/text
29. https://www.providencejournal.com/story/news/healthcare/2024/07/18/olneyville-health-center-to-close-its-doors-july-31-due-to-care-shortage/74429383007/; https://www.bostonglobe.com/2024/09/13/metro/layoffs-thundermist-community-health-center-rhode-island-healthcare/; https://riattorneygeneral.my.canva.site/healthcare/#the-landscape; https://turnto10.com/news/local/care-new-england-moves-to-shut-down-services-at-memorial-hospital
30. https://pestakeholder.org/wp-content/uploads/2025/03/PESP_Report_IDD_2025.pdf; https://rhodeislandcurrent.com/2025/05/20/private-equity-snaps-up-disability-services-challenging-state-regulators/; https://www.prnewswire.com/news-releases/gi-alliance-expands-east-coast-presence-with-rhode-island-gi-partnership-302041383.html.

State is experiencing an influx of private equity-backed or other for-profit firms, which has the potential to increase prices, exacerbate workforce shortages,[31] and harm access to and quality of care.[32] Despite these concerns, Rhode Island lacks a comprehensive state plan to address private equity involvement and health care consolidation holistically. Private equity-backed health care models have also exposed regulatory gaps involving medical malpractice coverage and captive insurer insolvency.[33]

- **Unequal Access and Outcomes.** Despite the State's efforts over the years to reduce health disparities, Rhode Islanders who are non-white, low-income, or part of historically under-resourced and under-served communities continue to have less access to health care services and poorer health outcomes. Hispanic Rhode Islanders are significantly more likely to be uninsured.[34] Black, Hispanic, and other non-white Rhode Islanders are more likely than white Rhode Islanders to lack a primary care provider and forgo routine checkups – often due to cost-related barriers.[35] Similarly concerning disparities exist in access to dental care, compounding inequities in overall health.[36] These gaps translate to worse health outcomes and higher rates of illness and mortality among marginalized groups.[37] Yet there remains no single agency responsible for addressing these disparities in a coordinated, strategic way. The lack of a unified response has directly harmed Rhode Islanders. Any large-scale policy reforms, such as those proposed herein, must consider and respond to these inequalities to ensure that health outcomes improve for all Rhode Islanders.
- **Failure to Address Social Determinants of Health.** Leading Rhode Island stakeholder groups have raised urgent concerns about the deterioration in social determinants of health. These include record-high food insecurity,

31. https://www.hhs.gov/sites/default/files/hhs-consolidation-health-care-markets-rfi-response-report.pdf, at 5 (reporting that "consolidation reduces wage growth for health care workers" and "magnifies restrictive impact of non-compete clauses").
32. https://www.kff.org/health-costs/issue-brief/one-or-two-health-systems-controlled-the-entire-market-for-inpatient-hospital-care-in-nearly-half-of-metropolitan-areas-in-2022/ (reporting Providence-Warwick MSA Herfindahl-Hirschman Index (HHI) of 1,949 for inpatient acute care, categorized as "highly concentrated"); https://jamanetwork.com/journals/jama-health-forum/fullarticle/2829224 (reporting on primary care consolidation with hospital systems or private equity and finding that RI PCP consolidation rates exceeded 25% in most of the state, and exceeded 50% in some portions of the state); https://hsph.harvard.edu/news/private-equitys-appetite-for-hospitals-may-put-patients-at-risk/
33. https://www.propublica.org/article/prospect-medical-malpractice-bankruptcy-hospitals-doctors-philadelphia
34. https://health.ri.gov/data/healthcare-access
35. https://health.ri.gov/data/healthcare-access
36. Health Care System Planning Foundational Report - December 2024.pdf at 80.
37. *See, e.g.*, https://health.ri.gov/sites/g/files/xkgbur1006/files/2025-03/2023-hiv-surveillance-report.pdf (reporting higher incidence and prevalence of infectious diseases, including tuberculosis, HIV, and sexually transmitted infections, among Black, Hispanic, and other racial and ethnic minorities, and higher incidence of HIV among Rhode Islanders who are transgender or otherwise gender-diverse).

increasing enrollment barriers in essential nutritional programs like the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and administrative failures in key enrollment systems like RIBridges, which is a statewide platform used to administer many of Rhode Island's health and human services programs.[38] Meanwhile, the State is also facing a housing crisis, with soaring housing costs, racial and ethnic disparities in homeownership, material losses of federal funds to support housing, and a general reluctance to declare a homelessness emergency.[39] For Rhode Island's children, persistent lead exposure, housing instability, and underfunded income supports further highlight the neglect of the root causes behind poor health outcomes.[40]

## B. Current Regulatory Structure

Rhode Island's health care system is regulated by a patchwork of state agencies, each performing unique regulatory functions (see Figure 2). The Executive Office of Health & Human Services (EOHHS), a cabinet-level agency led by the Secretary of EOHHS, was originally created in 2005 as an "umbrella agency" to provide coordinated and centralized oversight of various subagencies' health regulatory functions. However, in practice, EOHHS broadly delegates many functions to subagencies without sufficient monitoring or course-correcting. Furthermore, the demands of vital day-to-day operations leave the agency with limited resources and expertise to engage in long-term strategic planning. This lack of centralized governance and attention to long-term priorities has resulted in policy inconsistencies, regulatory silos, and gaps in oversight. It exposes the State to decision paralysis, creates a risk of regulatory capture, and leaves regulators unequipped to monitor, prevent, and remediate systemic threats.

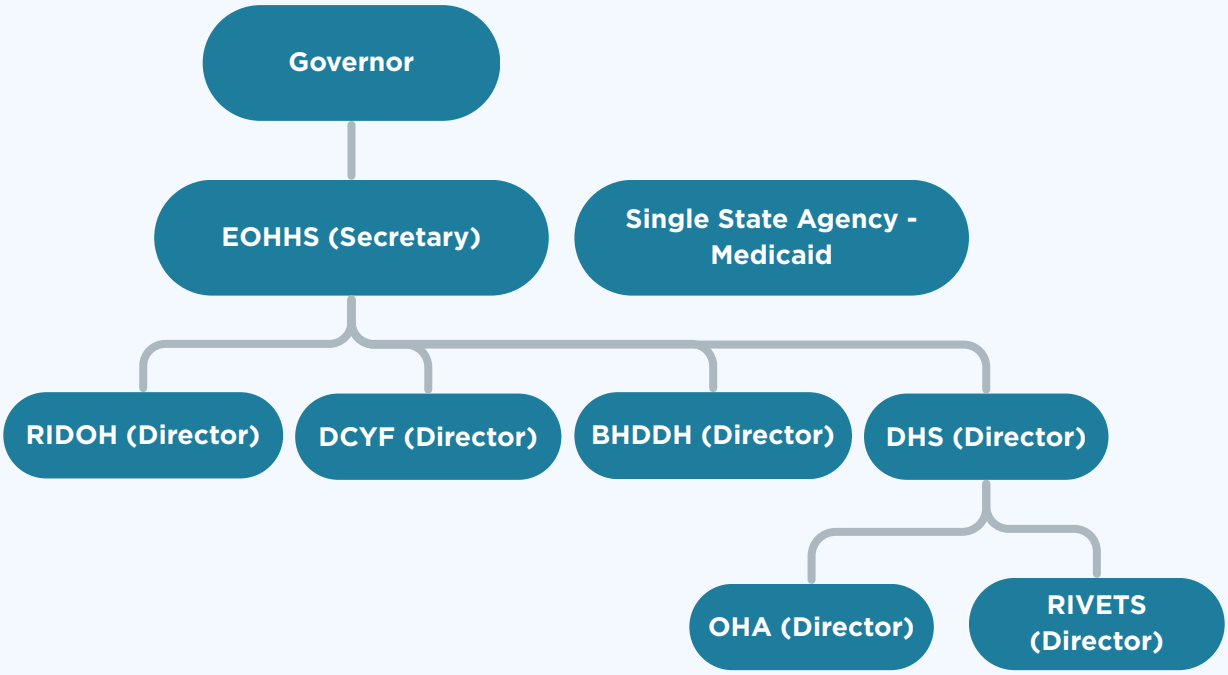
There are six subagencies under EOHHS, each responsible for a range of health-related programs and regulatory functions: the Rhode Island Department of Health (RIDOH); the Department of Behavioral Healthcare,

38. RIBridges has many lines of defense. How was the system breached? • Rhode Island Current; https://rifoodbank.org/wp-content/uploads/2024/11/2024-Status-Report_Web.pdf; https://www.bostonglobe.com/2024/11/25/metro/two-in-five-rhode-island-households-food-insecure-2024-report/.
39. https://rhodeislandcurrent.com/wp-content/uploads/2025/02/HWRI_HFB24.pdf; RI legislators call on Gov. Dan McKee to declare homelessness a public health emergency - The Brown Daily Herald
40.https://rikidscount.org/wp-content/uploads/2024/08/2024-Rhode-Island-KIDS-COUNT-Factbook.pdf; RISN_2024_15_web-with-Table-1-correction-—-FINAL.pdf; New KIDS COUNT Factbook outlines what's a stake for vulnerable R.I. kids • Rhode Island Current

Developmental Disabilities and Hospitals (BHDDH); the Department of Children, Youth and Families (DCYF); and the Department of Human Services (DHS), which includes the Office of Healthy Aging (OHA) and the Office of Veterans Services (RIVETS). In addition to EOHHS and its subagencies, several other agencies are responsible for specific health care regulatory functions in the state. These include the Office of the Health Insurance Commissioner (OHIC), which is organized under the Department of Business Regulation (DBR), HealthSource RI (HSRI), housed within the Department of Administration (DOA), and the Rhode Island Office of the Attorney General (RIAG), which plays a key role in oversight and enforcement related to hospital conversions, consumer protection, health care access, and Medicaid fraud and abuse.

**Figure 2. Current Structure and Responsibilities of Rhode Island Health Regulators**

EOHHS Organizational Chart[41]




***Executive Office of Health & Human Services (EOHHS).*** EOHHS serves as Rhode Island's umbrella agency for health and human services regulation. EOHHS' Central Management division coordinates programmatic and administrative functions for the four health and human services subagencies, including budget, finance, and legal services.[42] EOHHS is also designated as the Single State Agency for purposes of Medicaid administration, giving it broad authority over Medicaid policy in the State. This authority includes designing and implementing new Medicaid financing models, such as Rhode Island's Accountable Entity (AE) program, under which EOHHS holds AEs consisting of contracted providers responsible for costs of care for attributed Medicaid enrollees. EOHHS also conducts data collection related to the Medicaid program, and its enforcement authority primarily focuses on Medicaid enrollment

41. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2025-01/EOHHS%20Strategic%20Plan%20Base%20Document-%202024%20V3%20%28FINAL%29.pdf
42. Executive Office of Health and Human Services.pdf

determinations and oversight of Medicaid-related certifications made by providers.[43] The agency is led by a Secretary, who is appointed by the Governor and confirmed by the Senate.

- **Rhode Island Department of Health (RIDOH):** RIDOH serves as the State's primary public health authority, responsible for preventing disease and protecting the health and safety of Rhode Islanders. It investigates disease outbreaks, enforces sanitary and health laws, maintains vital records, and administers regulations related to public health, facility standards, patient safety, and professional licensing standards. Through its licensing and oversight of health care professionals, facilities (including hospitals), and other health care programs, RIDOH plays an essential role in health system regulation.[44] RIDOH is led by a Director who serves a five-year term, is appointed by the Governor, confirmed by the Senate, and must be a physician with public health experience.[45]
- **Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH):** BHDDH oversees the State's mental health, substance use, and developmental disability services. Among other vital services, BHDDH's largest programs help to arrange supportive employment, community-based and residential support, shared living arrangements, day programming, and transportation services for individuals with developmental disabilities.[46] BHDDH also operates several of the Rhode Island's public health care facilities, including Eleanor Slater Hospital (the State's only long-term acute care hospital) and the Rhode Island State Psychiatric Hospital.[47] BHDDH is led by a Director, who is appointed by the Governor, confirmed by the Senate, and serves at the pleasure of the Governor.

43. RIF_Legal-and-Regulatory-Framework-Executive-Summary_share.pdf; https://www.rilegislature.gov/housefiscalreport/2020/EOHHS%20FY%202025.pdf
44. RIGL 23-1-1 et seq.; RIDOH, About RIDOH (last visited July 14, 2025), https://health.ri.gov/about-us
45. https://www.rilegislature.gov/commissions/OARIC/commdocs/04-25-2025--RIDOH%20presentation.pdf
46.https://www.rilegislature.gov/Special/comdoc/Senate%20Finance%205212020/Department%20of%20Behavioral%20Healthcare%20Developmental%20Disabilities%20and%20Hospitals.pdf
47. See RIGL § 40.1-1-3.1 et seq; Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH), https://bhddh.ri.gov/about-us

- **Department of Human Services (DHS):** DHS administers numerous public assistance and social service programs in the State, including administering eligibility for Medicaid, Supplemental Nutrition Assistance Program (SNAP), and RI Works, among other programs.[48] DHS is led by a Director, who is appointed by the Governor, confirmed by the Senate, and serves at the pleasure of the Governor. DHS also oversees initiatives for veterans and the elderly through dedicated offices:
    - **Office of Healthy Aging (OHA):** OHA serves as the State's designated unit on aging, responsible for developing policies and programs that support the well-being of older adults. OHA coordinates a continuum of services for seniors – including nutrition, health care, and home care programs and caregiver support. OHA also advocates for the needs of older adults and adults with disabilities, carrying out functions such as investigating reports of elder abuse, neglect and exploitation.[49] OHA is led by a Director, who is appointed by the Governor and confirmed by the Senate.
    - **Office of Veterans Services (RIVETS):** RIVETS supports the state's military veterans, service members, and their families through coordination and advocacy related to veterans benefits and programs, including access to the federal VA health care system. RIVETS also operates the Rhode Island Veterans Home, a 208-bed residential care facility for veterans.[50] RIVETS is led by a Director, who is appointed by the Governor and must be an honorably discharged war veteran.
- **Department of Children, Youth and Families (DCYF):** DCYF is responsible for child welfare, children's behavioral health, and juvenile justice programs in Rhode Island. It administers a statewide network of supports to protect vulnerable children and families through three operational divisions: Children's Behavioral Health Services,

48. *See* RIGL § 40-1-1 et seq; Department of Human Services, About Us, https://dhs.ri.gov/about-us
49. *See* RIGL § 42-66-4; OHA, Who We Are, https://oha.ri.gov/who-we-are
50. RIVETS, Rhode Island Veterans Home, https://vets.ri.gov/find-your-benefits/ri-veterans-home

Child Welfare (including child protective services, family services, and permanency supports), and Youth Development Services, which oversees the Rhode Island Training School and juvenile probation.[51] DCYF is led by a Director who serves a four-year term, is appointed by the Governor, confirmed by the Senate, and holds a master's degree in social work or a closely related field with demonstrated experience in child welfare, children's mental health, or juvenile justice, and has at least five years of progressively responsible experience administering programs for children.

***Office of the Health Insurance Commissioner (OHIC).*** The Office of the Health Insurance Commissioner (OHIC), administratively housed within the Department of Business Regulation (DBR), oversees state-regulated health insurers and other risk-bearing organizations, while also performing a wide variety of health policy functions. These responsibilities include reviewing health insurance rates in the state's Affordable Care Act (ACA) marketplace, monitoring total health care expenditures, and administering hospital rate caps, among other regulatory activities. OHIC has played an important role in health care reform efforts, such as establishing primary care affordability standards to promote payor investment in primary care, establishing limits on insurer prior authorization for certain services, and participating in the Care Transformation Collaborative of Rhode Island (CTC-RI), an all-payor initiative to promote innovative reimbursement and delivery programs. OHIC is led by a Commissioner, who is appointed by the Governor with consent of the Senate.

***HealthSource RI (HSRI).*** HSRI administers Rhode Island's ACA insurance exchange,[52] facilitating enrollment in ACA plans across several markets, including qualified health plans and the Small Business Health Options Programs. The agency determines eligibility for premium tax credits and cost-sharing reductions, administers plan enrollment and disenrollment, processes premium payments and coverage terminations, and handles various appeal processes. HSRI operates under the administrative oversight of the Department of Administration (DOA) and is governed by an advisory board whose members are appointed by the Director of DOA. Daily operations are managed by a Director, who is appointed by the Director of DOA, and a senior executive team.

51. *See* RIGL § 42-72-1 et seq; FY 2025 DCYF Budget, https://www.rilegislature.gov/Special/comdoc/Senate%20Finance%205212020/FY2025%20Department%20of%20Children,%20Youth,%20and%20Families%20Budget.pdf\
52. R.I. Gen. Laws § 42-157-1 et seq.

***Rhode Island Office of the Attorney General (RIAG).*** The Office of the Attorney General plays a key role in advocating for the rights of patients and consumers while serving as a co-regulator alongside RIDOH in overseeing hospital conversions. Statutory responsibilities include reviewing hospital conversions and other material transactions involving health care organizations, enforcing state consumer protection laws pertaining to health care and health insurance, investigating and prosecuting Medicaid fraud, waste and abuse, and advocating for patients and consumers under the Health Care Advocate statute. Over time, the Office's role has increasingly focused on policy leadership, regulatory action and legislative advocacy, reflecting an increase in both the growing frequency and scale of major crises facing Rhode Island's health care system and a commitment to advancing solutions that address the root causes of systemic weakness and instability.

## C. Recent Calls for Administrative Change

Although EOHHS may have been established with the intention of serving as a unified oversight framework, its "umbrella" structure has revealed significant limitations since its 2005 inception. In recent years, a growing number of key stakeholders have called for the reorganization of EOHHS and the broader health care regulatory system to increase accountability and improve the management of the state's health system.

### 1. Special Legislative Commission (September 2022)

In 2021, the Rhode Island General Assembly established the *Special Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of Health and Human Services Programs in the State of Rhode Island* ("Special Legislative Commission" or "SLC").[53] Composed of members of the General Assembly and other stakeholders with expertise and experience with EOHHS and its subagencies, the SLC published a detailed report drawing on extensive input from EOHHS, its subagencies, and a range of

53. https://webserver.rilegislature.gov/BillText21/SenateText21/S0985.htm

experts and community stakeholders. As detailed further in the report:

> *The structure and functions of the Executive Office of Health and Human Services have not been thoroughly examined since its inception in 2005. Over the past 17 years, the health and human services landscape in Rhode Island has changed greatly. The commission acknowledges that there remains a need for a strong, efficient executive office that focuses on alignment and coordination, quality improvement, and sub-agency support; it also recognizes that EOHHS has some unique responsibilities not easily replicated by individual agencies . . . .*
>
> *The commission closely evaluated EOHHS and its sub-agencies and learned about the strengths and weaknesses of the current structure. The commission's recommendations aim to address some of the weaknesses within EOHHS, but also build on the existing strengths, including the EOHHS data ecosystem, centralization of financial services, and various media campaigns . . . .*
>
> *The commission's intent is that the recommendations outlined herein are executed in an expeditious manner with the least possible disruptions to services. Many of the recommendations involve major structural changes within EOHHS and its sub-agencies. The commission recognizes the challenges associated with such changes and believes that appropriate planning is necessary for success, including realistic timelines and strong inter-agency collaboration.*[54]

The SLC organized its proposals into eight key recommendations (see Appendix 1). Common themes in the SLC's recommendations included: (1) changing EOHHS appointment authorities to better reflect the importance of certain functions (e.g., Medicaid) and increase accountability across EOHHS and its subagencies; (2) achieving coherence in agency oversight by transferring functions to departments with the most relevant expertise; (3) establishing new accountability mechanisms to ensure agencies are aligned with and evaluated against long-term strategic objectives; and (4) revising staffing, recruitment, and retention policies to promote talent acquisition and reallocate personnel in a way that better reflects the relative utilization of programs.

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54. Final Report - Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of HHS Programs in RI.pdf at 5-6.

These recommendations validate many of the current shortfalls in Rhode Island's health care regulatory ecosystem and highlight clear opportunities for improvement within EOHHS. Importantly, versions of some SLC recommendations have been implemented with varying degrees of success – including the creation of the HCSP Cabinet.[55] However, many critical, and larger-scale reform recommendations remain unaddressed. In particular, the Medicaid program, which is the State's largest benefit program, is relegated within EOHHS and lacks a standalone department. The relative deprioritization of the Rhode Island's Medicaid agency has contributed to long-term stagnancy in state investments, insufficient staffing and resources to design and implement large-scale system reforms, and a heavy reliance on private contractors to administer Medicaid benefits.

**2. The Rhode Island Foundation's Manatt Report (December 2022)**

In 2022, the Rhode Island Foundation engaged Manatt, Phelps & Phillips, LLP (Manatt) to assess the regulatory structure of Rhode Island's health care system and create a framework for improvement. This culminated in the release of a compilation of reports, including an executive summary of Manatt's initial findings and a detailed inventory of state health care regulatory functions across state agencies.[56]

The Manatt report describes Rhode Island's regulatory structure as a "patchwork" that addresses four key domains: **quality, affordability, accessibility, and equity**. More specifically, it notes that the health care system is regulated based on component parts — "no agency or department oversees the entire system of care," and "[n]o authority exists for state agencies or departments, either alone or in concert, to regulate entire systems of care in a comprehensive and cohesive manner."[57] The report continues:

> *Efforts to improve the cohesiveness and comprehensiveness of how Rhode Island regulates and oversees hospitals and providers should take into account the breadth of existing authority granted to agencies and departments, the ways in which such authorities are exercised, and the financial and staffing support necessary for each agency or department to implement and oversee its regulations.*[58]

55. https://eohhs.ri.gov/RI-Health-Care-System-Planning
56. https://assets.rifoundation.org/documents/RIF_Legal-and-Regulatory-Framework-Executive-Summary_share.pdf
57. *Id.* at 1 (internal quotes omitted).
58. *Id.* at 2.

The report's detailed inventory of the health regulatory functions and authorities reiterates that Rhode Island generally regulates health care at the licensed facility level rather than overseeing the entire system of care. With respect to EOHHS, the report concluded that the agency had limited independent authority to review hospital or provider finances and limited enforcement authority.[59] Most requirements relating to access, oversight and quality of care fall within RIDOH's regulatory authority, with the State's Medicaid agency focusing on quality of care and access with respect to Medicaid beneficiaries.

The Manatt report found that RIDOH did not take an active role in reviewing financial information of health care providers.[60] RIDOH's authority to impose data reporting obligations and to publicly share data trends is either infrequently exercised and not as comprehensive as intended under its statutory authority.[61] For example, under RIDOH's Healthcare Quality Reporting Program, the agency is authorized to develop a quality performance measurement and reporting program for hospitals and providers, establish a unified quality and value database, and report annually to the General Assembly and Governor on performance trends, areas for quality improvement, and future objectives.[62] These reports have not been published since before the COVID-19 pandemic, and for some provider types, such as hospitals, RIDOH's public reports have not been updated since 2018.[63] RIDOH also imposes charity care, uncompensated care, and community benefit requirements but performs minimal compliance oversight over these obligations.[64] RIDOH's enforcement tools are generally limited to licensure actions, imposition of compliance orders, and "minor fines."[65]

The Manatt report also describes oversight of health care affordability as primarily falling under the Office of the Health Insurance Commissioner (OHIC), despite the fact that OHIC's statutory authority in the affordability realm is largely focused on conducting insurance rate review and establishing health

59. R.I. Found., Summary of Existing Legal and Regulatory Framework and Select State Profiles, at 22 (Feb. 2023).
60. R.I. Found., Summary of Existing Legal and Regulatory Framework and Select State Profiles, at 7 (Feb. 2023).
61. *Id*. at 11.
62. R.I. Gen. Laws §§ 23-17-10, -5.
63.https://health.ri.gov/sites/g/files/xkgbur1006/files/publications/qualityreports/hospitals/HospitalSummaryReport.pdf
64. R.I. Found., Summary of Existing Legal and Regulatory Framework and Select State Profiles, at 14 (Feb. 2023).
65. *Id*. at 7.

insurer spending targets and hospital rate caps. Notably, OHIC's regulation of health care providers is generally indirect, arising from its broad regulatory authority over health insurers.[66] For example, OHIC regulates insurers' rates and payment methodologies, including regulating target spending levels for certain clinical service lines.[67] OHIC's oversight and enforcement operate primarily through insurer self-reporting, supplemented with ad-hoc market conduct examinations.[68] This approach is concerning, as insurers may be disinclined to self-report violations, and OHIC's lack of authority over providers limits its ability to ensure affordability goals are met. Importantly, OHIC's regulatory authority generally does not extend to self-funded group health plans, which represent a large portion (approximately two-thirds) of the commercial health insurance market.[69] and are primarily regulated under the federal Employee Retirement Income Security Act of 1974 (ERISA).

Consequently, Rhode Island's health care regulatory agencies lack the capacity and authority to effectively and reliably oversee the State's health care system. Insufficient data collection and analysis leave agencies unable to anticipate, prevent, or respond to fiscal and operational pressures that impact access to care. Recent challenges across provider organizations underscore these gaps in oversight. Structural reforms must be made to ensure each agency's mission and core functions align with the needs of Rhode Islanders.

## D. Opportunities for Policy Reform in Rhode Island

Collectively, these findings underscore the urgent need for comprehensive policy reforms to enhance coordination, accountability, and effectiveness across Rhode Island's health care regulatory system. The regulatory system that governs health care and public health in Rhode Island performs numerous essential functions to support and maintain the delivery of health care and related services. The system is central to the well-being of Rhode Islanders and is tasked with an impressive scope of work with a dedicated and talented public health workforce. Yet, Rhode Island has not built or invested in the kind of public health and regulatory infrastructure that other states have leveraged to maximize the State's regulatory and investment impacts.

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66. *Id*. at 7. Recent legislation expanded OHIC's authority beyond insurers to include some oversight of large health care providers, including setting cost-growth targets, requiring performance improvement plans, and imposing financial penalties for noncompliance. It remains to be seen how this authority will be implemented and applied.
67. *Id*.
68. *Id*.
69. https://healthsourceri.com/wp-content/uploads/WG-2-Affordability_Final.pdf at 6

With a well-designed and well-resourced health regulatory system, Rhode Island could pursue reforms that are currently out of reach. A focused, data-driven, and systemic regulatory approach would enable the State to effectively address its most pressing health policy challenges, improving access, controlling costs, and advancing health equity.

- **Pursuing Systemic Health Care Financing Reform:** Rhode Island currently benefits from high rates of insurance coverage; however, this masks emerging threats from federal Medicaid and ACA cuts, as well as health care cost growth that requires bold, innovative, state-driven solutions. The rising cost of insurance has vastly outpaced wage growth in the State. Premiums for the largest insurers in the ACA individual market have risen roughly 50% over the past 5 years and are set to increase further in plan year 2027.[70] Meanwhile, median household income rose by just 2.1%.[71] As compared to the median household income in Rhode Island of roughly $83,000 in 2024, the unsubsidized cost for a mid-tier ("silver plan") on the ACA Individual Market for a 60-year old couple now exceeds $35,000 per year.[72] The lack of affordability puts coverage for tens of thousands of Rhode Islanders in jeopardy, and even those with stable coverage often lack access to vital forms of care and face high deductibles and cost-sharing. Although the legislature recently enacted the Rhode Island Marketplace Affordability Program to provide premium subsidies to eligible consumers, the program offers targeted relief to only a limited subset of the Affordable Care Act marketplace population; further action must be taken to address the affordability crisis. Future policy must build on the promising steps regulators have taken to date, such as OHIC's cost-growth caps,[73] participation in multi-payor demonstration programs like the AHEAD model that promote systemwide/upstream financing approaches,[74] and the HCSP Cabinet's initial health care planning efforts.[75] To date, these projects have been implemented in piecemeal or for limited durations, and have not entailed systemic reform of the state's health financing system.

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70. RIAG Post-Hearing Brief, Plan Year 2026 OHIC Rate Review Hearing for BCBSRI (July 2025), at 2; RIAG Post-Hearing Brief, Plan Year 2026 OHIC Rate Review Hearing for NHPRI (Aug. 2025), at 2.
71. RIAG Post-Hearing Brief, Plan Year 2026 OHIC Rate Review Hearing for NHPRI (Aug. 2025), at 2.
72. https://healthsourceri.com/wp-content/uploads/OE2026-IF_English_Web_Final.pdf, at 5.
73. OHIC is a national leader through the implementation of Affordability Standards to lower cost and improve quality, https://ohic.ri.gov/policy-reform/affordability-standards.
74. *E.g.* Rhode Island Medicaid implemented value-based care strategies through the Accountable Entities program, https://eohhs.ri.gov/initiatives/accountable-entities. See also https://eohhs.ri.gov/initiatives/completed-initiatives/state-innovation-model-sim-grant (Rhode Island State Innovation Model (SIM) Test Grant); https://ctc-ri.org/01/16/2025/commissioner-king-shares-insight-ri-joining-cms-ahead-model (AHEAD Model).
75. https://eohhs.ri.gov/RI-Health-Care-System-Planning/Reports

The RIAG proposes introducing a Comprehensive Public Option to compete with private insurance companies and centralize state-control over health care financing, but implementing reforms such as this will require additional technical expertise and administrative infrastructure. A reorganized and better resourced regulatory entity could develop and implement bold, system-level reforms like a Comprehensive Public Option to sustainably control health care costs for Rhode Islanders. Until then, the lack of a dedicated and permanent agency to pursue these reforms will continue to produce fragmented and less efficient approaches to health policy analysis and implementation, and state regulators will only be able to provide high-level directional guidance that does not drive meaningful health financing reform.

- **Improving Access and Affordability of Prescription Drugs:** Prescription drugs are a significant driver of health care spending in Rhode Island, rising 11.8% between 2023 and 2024 despite essentially flat utilization, due to skyrocketing drug prices.[76] In turn, high drug costs render medically necessary medications out of reach for some consumers, contribute to nonadherence to medication regimens, and – if covered by payors – increase pharmacy spend and put upward pressure on premium rates. Pharmacy benefit managers (PBMs) have exerted an outsized and harmful influence on drug spending, benefiting from rising drug prices without delivering promised consumer savings.[77] To date, there has been no coordinated state effort to address drug pricing. Reforms pursued by other states, like creation of prescription drug boards, state-managed formularies, or prescription drug purchasing pools, require focused attention and policy analysis that is not currently available in Rhode Island. Reorganizing Rhode Island's regulatory agencies and introducing new functions and resources would enable policymakers to evaluate these existing programs or generate new, state-specific initiatives to address issues in drug pricing.
- **Access to Primary Care:** There are not enough primary care providers in the state to meet the needs of Rhode Islanders.[78] While state policymakers have begun examining some of the underlying workforce trends,[79] incremental

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76. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2026-05/OHIC%20Cost%20Trends%20Report_Final%2005.18.2026.pdf
77. *See* Complaint at 26-46, Rhode Island v. Caremark PCS Health, LLC, No. PC-2025-02760 (R.I. Super. Ct May 27, 2025)
78. https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2025-02/Health%20Care%20System%20Planning%20Foundational%20Report%20-%20December%202024.pdf at 62 ("Rhode Island is expected to have a deficit of almost 100 primary care providers by 2030" and "published provider counts dramatically overestimate primary care capacity in Rhode Island, because many primary care providers are not working full-time and are not serving full patient panels.")
79. https://eohhs.ri.gov/health-workforce-dashboard

proposals—like small loan forgiveness initiatives, which will likely take years to show results—are not sufficient to address today's crisis. A reimagined regulatory system could leverage payment structures and provider expertise to examine new ways of delivering care. For example, a new agency could explore the viability of state-incentivized patient intake centers, a more standardized and interoperable health information exchange, and the adoption of other centralized primary care delivery methods that place less focus on coding, billing, and paperwork burdens and more value on patient care time. Additionally, a new agency could take on analytic and policy roles traditionally outsourced to consultants. Policymakers recently commissioned a feasibility study on establishing a medical school at the University of Rhode Island.[80] Rather than relying solely on third-party consultants to make such a recommendation and perform the necessary feasibility study, an agency with the right policy expertise, analytical capacity, and local knowledge could perform the requisite analysis in-house, provide targeted recommendations to the legislature, and contextualize the proposal alongside other potential options for boosting in-state recruitment and retention of health care professionals.

- **Combating Fraud, Waste, and Abuse:** An adequately resourced health care regulatory system should be able to detect new patterns of financial manipulation and act to prevent them. Health care dollars are limited in Rhode Island, and it is incumbent upon the State to monitor and enforce regulations that are designed to safeguard the efficient and appropriate use of funds we do have. These efforts are made easier when state regulatory agencies are sufficiently resourced to engage in proactive data collection and trend analysis and are aligned on enforcement priorities. One area that is ripe for program integrity improvement involves the misuse of related entities to siphon profits from health care providers in the State. As the RIAG has noted in comments submitted to the Health Services Council, current regulatory procedures are not adequately prevented from using sophisticated schemes whereby out-of-state or private equity owners acquire nursing homes or hospice practices to channel federal and state funds to themselves through corporate affiliates. These funds, which are intended to provide care to Rhode Island's poorest and most vulnerable populations, are too often redirected to enrich private interests that have little or no connection to the State.[81] Working in tandem with other

80. Proposed URI medical school could fill doctor shortage, boost economy, draft report finds - TPR: The Public's Radio

81. *See, e.g.*, RIAG Comments in Re: application of Coventry Operations RI LLC for a Change in Effective Control, at 2, 6-7 (Apr. 18, 2025).

enforcement authorities, a reinvigorated health regulatory agency prepared to monitor this kind of activity could help to identify and analyze these exploitative transactions and ensure that each dollar intended to provide care is actually being used for that purpose, and not for private profit.

While the national conversation has moved away from large-scale health care reform at the federal level in recent years, the need for meaningful reform remains urgent. Rhode Island is at an inflection point, requiring system-level solutions to address its system-level problems. Although the State has made some progress in promoting payment reform,[82] and local leaders have advanced this conversation,[83] bold new ideas and greater leadership are needed to effect meaningful change.

82. OHIC is a national leader through the implementation of Affordability Standards to lower cost and improve quality, https://ohic.ri.gov/policy-reform/affordability-standards; Rhode Island Medicaid implemented value-based care strategies through the Accountable Entities program, https://eohhs.ri.gov/initiatives/accountable-entities.
83. https://eohhs.ri.gov/RI-Health-Care-System-Planning

# II. Effective Health System Regulation: Lessons from Other States

This Proposal draws upon lessons from other states' health care regulatory frameworks and Rhode Island-specific case studies to highlight the limitations of the current system and demonstrate the benefits of adopting the proposed reforms herein. There is no one-size-fits-all approach and Rhode Island will ultimately require a structure that is tailored to its particular conditions. However, a number of states, such as Massachusetts, Maryland, Oregon, and Vermont, as detailed below, have implemented comprehensive and coordinated health care oversight and cost-containment structures that serve as valuable models for consideration in Rhode Island. Rather than replicating any single model, this proposal draws upon and adapts key elements from each state's approach that are most relevant to Rhode Island's unique needs and improves upon them to build a stronger, more effective, coordinated, and accountable health care regulatory system.

## A. Massachusetts

Massachusetts uses a bifurcated, but interrelated, health care regulatory model comprising the Health Policy Commission (HPC) and the Center for Health Information and Analysis (CHIA) – two independent state agencies established in 2012 – along with the Massachusetts Executive Office of Health & Human Services (MA EOHHS), which is comprised of 11 subagencies and oversees the state's Medicaid program. This summary focuses on the structural design features of the HPC and CHIA, while also noting how these agencies interact with certain regulatory functions assigned to MA EOHHS. Together, the HPC and CHIA oversee the state's strategy to monitor health care spending, promote transparency, and support payment and delivery system reform. This dual-agency structure reflects an intent to separate policy and oversight functions (residing with the HPC) from data collection and analysis functions (residing with CHIA), while still ensuring collaboration between them.

**Figure 3. Overview of MA Health Policy Commission and Center for Health Information & Analysis**

| Massachusetts Health Policy Commission (HPC) | Massachusetts Center for Health Information & Analysis (CHIA) |
|---|---|
| Governance: Independent agency not subject to the supervision and control of any executive office, governed by an 11-member board and managed by an executive director.<br><br>Board Membership: 2 ex officios and 9 members appointed by the Governor and Attorney General.<br><br>Functions:<br>• Set health care cost growth goals for the commonwealth<br>• Enhance the transparency of provider organizations<br>• Monitor the development of ACOs and patient-centered medical homes<br>• Monitor the adoption of alternative payment methodologies<br>• Foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care<br>• Monitor and review the impact of changes within the health care marketplace<br>• Protect patient access to necessary health care services (source) | Governance: Independent agency not subject to the supervision or control of any executive office, governed by an 11-member oversight council and managed by an executive director.<br><br>Council Membership: 4 ex officios and 7 members appointed by the Governor, Attorney General, and State Auditor.<br><br>Functions:<br>• Authority to compel the submission of data from various health organizations - e.g., health plans, hospitals, medical groups, community health centers, nursing homes, etc.<br>• Creates and curates major health databases, including MA All Payor Claims Database, Hospital Discharge Database, Provider Financial Report Database, and Registry of Provider Organizations.<br>• Releases numerous publications, reports, interactive dashboards, and databooks documenting features of the Massachusetts healthcare system.<br>• Functions as a center of excellence for data and analytics in state government, providing custom data extracts, ad hoc analyses, and support for sophisticated data operations. (source) |

### 1. The Massachusetts Health Policy Commission

The Massachusetts Health Policy Commission (HPC) is an independent state agency responsible for monitoring the performance of Massachusetts's health care system, particularly with respect to cost containment and care quality. The HPC's mission is to advance a transparent, accountable, and equitable health care system through policy leadership, data-driven oversight, and investment programming – aimed at achieving better health outcomes and ensuring high-quality care at lower cost for all residents.[84]

The HPC is governed by an 11-member Board of Commissioners, comprising ex-officio executive officials and appointees of the Governor and the Attorney General.[85] Board members serve without compensation, and appointments are designed to reflect diverse health care expertise, including members with expertise in health care delivery, health economics, behavioral health, labor/workforce organization, and consumer advocacy. The Executive Director, appointed by a majority vote of the Board, oversees the agency's staff, which is organized into several components: two executive offices (the Office of the Chief of Staff and the Office of the General Counsel); three programmatic departments (Health Care Transformation and Innovation, Market Oversight and Transparency, and Research and Cost Trends); and four policy-area specific offices (the Behavioral Health Workforce Center, Office of Health Resource Planning, Office of Patient Protection, and the Office of Pharmaceutical Policy and Analysis).

The HPC's regulatory functions include setting and monitoring the state's health care cost growth benchmark, analyzing market transactions for cost and access implications, and implementing strategic investments through grant-making programs such as the Community Hospital Acceleration, Revitalization, and Transformation (CHART) initiative.[86] The HPC enforces compliance with the state's health care cost growth benchmark through a performance improvement plan (PIP) mechanism. Health care entities that exceed the cost growth benchmark may be required to develop, submit, and implement a PIP outlining specific strategies to reduce cost growth and improve efficiency.[87]

84. Mass. Gen. Laws ch. 6D.
85. https://masshpc.gov/about/board
86. M.G.L. ch. 6D, §§ 10-12.
87. https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fmasshpc.gov%2Fsites%2Fdefault%2Ffiles%2F2023-06%2F1._pip_-_general_instructions.docx&wdOrigin=BROWSELINK

The Commission has the authority to impose civil penalties of up to $500,000 for failure to comply.[88] The HPC's Office of Patient Protection (OPP) also enforces patient rights under Chapter 176O, which establishes health insurance consumer protections, as well as other statutes, including those that govern internal and external review processes for health plan coverage decisions. Although the HPC does not directly administer the Massachusetts Medicaid program (MassHealth), it plays a significant indirect role in steering Medicaid policy. For example, HPC's policy frameworks, including its calculated benchmarks and alternative payment model designs, influence MassHealth reimbursement and coverage policies. The HPC also certifies Accountable Care Organizations (ACOs) participating in MassHealth's programs.

The HPC operates with a modest but stable budget, totaling approximately $11.4 million in FY 2024.[89] The agency's funding sources include legislative appropriations, assessments on hospitals and ambulatory surgical centers, and special funds, such as the Healthcare Payment Reform Fund and the Distressed Hospital Trust Fund.[90] The agency is statutorily exempt from executive agency budgetary approval, allowing it to allocate resources independently, in accordance with its regulatory mandate.[91]

Protections to promote public accountability are embedded in HPC's organizational and statutory framework. For example, HPC conducts annual public cost trend hearings in collaboration with CHIA, solicits written testimony from providers and payors, and hosts open meetings of its board and advisory council. This facilitates stakeholder engagement and allows other agencies, such as the Office of Attorney General, to collaborate and intervene where appropriate.[92]

**2. The Center for Health Information and Analysis (CHIA)**

The Center for Health Information and Analysis (CHIA) was established as an independent agency responsible for collecting, analyzing, and disseminating health care data to support policy development and system improvement. CHIA serves as the agency of record for Massachusetts health care data,

88. M.G.L. ch. 6D, § 10. See also NASHP, Massachusetts Health Policy Commission Takes Steps to Hold High-Cost Health System Accountable (describing 2022 PIP imposed with respect to Mass General Brigham).
89. https://budget.digital.mass.gov/govbudget/fy24/appropriations/administration-and-finance/health-policy-commission/?tab=budget-summary
90. M.G.L. ch. 6D, §§ 6-7.
91. M.G.L. ch. 6D, § 2.
92. M.G.L. ch. 6D, § 8.

providing reliable, objective, and meaningful analysis of system performance.[93]

CHIA is governed by an 11-member Oversight Council, comprised of both ex officio executive officials and appointees of the Governor, Attorney General, and State Auditor. Council members serve five-year terms and must be unaffiliated with major industry stakeholders. The Oversight Council meets quarterly in publicly accessible sessions. CHIA's Executive Director, who manages day-to-day operations, is jointly appointed by the Governor, Attorney General, and State Auditor.[94]

CHIA has a staff of more than 150 people and is structured around an executive leadership team and six senior directors overseeing data operations, research, reporting, provider finances, health informatics, and legal compliance. CHIA maintains and operates several major data systems, including the Massachusetts All-Payer Claims Database (MA APCD), Acute Hospital Case Mix Databases, and several hospital and payor financial reporting systems.[95] CHIA enforces compliance with its reporting requirements through regulations, with penalties of up to $1,000 per week, not to exceed $50,000 annually, for noncompliance.[96]

CHIA's FY 2024 budget totaled approximately $39 million, nearly four times that of the HPC.[97] This funding differential is partly attributable to CHIA's larger staff and its extensive responsibilities for large-scale data collection and analysis. CHIA's revenue is primarily derived from assessments on payors and providers, rather than general appropriations.

### 3. Interagency Collaboration

Massachusetts' regulatory model illustrates a bifurcated governance structure where the HPC leads system oversight and regulatory functions, while CHIA serves as the data steward and analytic authority. This separation facilitates independence in both regulatory and analytic activities and allows for targeted expertise in oversight and evaluation. Both agencies operate outside of MA EOHHS, Massachusetts' single state Medicaid agency, yet their regulatory and policy initiatives are designed to support and advance the state's Medicaid goals.

93. Mass. Gen. Laws ch. 12C.
94. https://www.chiamass.gov/oversight-council/; Mass. Gen. Laws ch. 12C.
95. 957 CMR 8.00
96. 957 CMR 8.07(3)
97. CHIA FY24 Budget

The HPC and CHIA work together to monitor health care spending and measure performance relative to the cost growth benchmarks.[98] To advance this objective, the agencies review and influence individual payer and provider group spending performance through the authority to impose Performance Improvement Plans (PIPs) on regulated entities. Through this annual process, HPC conducts a robust review of organizations or payors referred by CHIA to understand cost drivers and opportunities for greater efficiencies.[99] Based on the findings of this review, the HPC may require the organization or payor to implement a PIP. For example, in 2022, Mass General Brigham ("MGB") was required to enter into a PIP after its commercial spending growth exceeded the set benchmarks between 2014 and 2019.[100] Within two years of being placed on a PIP, MGB delivered $197.1 million in savings by reducing utilization, price reductions, and shifting care to lower costs sites.[101]

Adopting elements of Massachusetts' dual-agency governance structure could strengthen Rhode Island's health policy framework by enhancing transparency, accountability, and data-driven decision-making. Establishing an independent data authority, alongside a distinct regulatory oversight body would promote objective analysis, reduce conflicts of interest, and improve coordination between regulatory functions, policy development and system performance monitoring.

## B. Maryland

Maryland employs a multi-agency regulatory framework designed to expand access, improve health system performance, and contain costs through a combination of grantmaking, data analytics, health planning, and all-payer rate setting. The state's principal health policy agencies include the Maryland Community Health Resources Commission (MCHRC), the Maryland Health Care Commission (MHCC), and the Health Services Cost Review Commission (HSCRC). While each commission operates independently within the Maryland Department of Health (MDH), their mandates are structurally aligned to promote affordability, equity, and quality across the continuum of care.

98. https://masshpc.gov/cost-containment/pips
99. *Id.*
100. https://masshpc.gov/sites/default/files/2023-06/pip-mgb-basis_notice_20220127.pdf
101. https://masshpc.gov/sites/default/files/PIP_MGB_March2024UpdateFinalReport.pdf

**Figure 4. Maryland Department of Health – Specialized Commissions**

| Maryland Community Health Resources Commission (MCHRC) | Maryland Health Care Commission (MHCC) | Health Services Cost Review Commission (HSCRC) |
|---|---|---|
| Governance: Independent commission; 11 members appointed by Governor.<br><br>Key Responsibilities:<br>• Expand access to health care in underserved communities;<br>• Support projects that serve low-income Marylanders, regardless of insurance status;<br>• Build capacity of safety-net providers;<br>• Council on Advancement of School-Based Health Centers;<br>• Implement the Maryland Health Equity Resource Act;<br>• Administer Maryland Consortium on Coordinated Community Supports. (Source) | Governance: Independent commission; 15 members appointed by Governor.<br><br>Key Responsibilities:<br>• Develop health care cost containment strategies to help provide access to appropriate quality health care services;<br>• Promote development of a health regulatory system that provides financial and geographic access to quality health care services at a reasonable cost;<br>• Facilitate the public disclosure of claims data for the development of public policy; analyze database and provide annual reports;<br>• Encourage development of clinical resource management systems to compare costs between various treatment settings (Md. Code Ann. § 19-103) | Governance: Independent commission; 7 members appointed by Governor.<br><br>Key Responsibilities:<br>• Establish hospital rates to promote cost containment, access to care, equity, financial stability and hospital accountability;<br>• Maintain and analyze data infrastructure that includes a uniform accounting and reporting system and extensive data collection on, and analysis of, every aspect of hospital operations;<br>• Provide annual reports on hospital operations;<br>• Publicly disclose information on the costs and financial performance of Maryland hospitals (Source) |

### 1. Maryland Community Health Resources Commission (MCHRC)

Created by the General Assembly in 2005, the Maryland Community Health Resources Commission (MCHRC) operates as an independent commission within MDH,[102] with a statutory mission to increase access to health care through community health resources, with a focus on underserved populations. The MCHRC serves as both a grant maker and policy incubator, supporting delivery system innovations that improve access and long-term sustainability.

The MCHRC consists of 11 commissioners appointed by the Governor, with mandated representation from hospitals, health plans, community providers, and unaffiliated health experts.[103] Commissioners may serve two four-year terms and are entitled to compensation. The Commission appoints an Executive Director, with gubernatorial approval, to oversee day-to-day operations. Staff capacity is modest but supported by consistent special fund appropriations. Specifically, MCHRC is supported through the Community Health Resources Commission Fund, consisting of assessments on nonprofit health service plans, appropriations from the Cigarette Restitution Fund, donations, grants, and investment earnings. The Fund is statutorily restricted to administrative expenses, grantmaking, and health data infrastructure development. The MCHRC's grantmaking budget has grown significantly in recent years, from $22 million in FY 2022 to a proposed $133 million in FY 2025.

Each year, the MCHRC issues a competitive Call for Proposals to fund projects in priority areas identified by commissioners, such as primary care, dental services, behavioral health integration, maternal and infant health, and health information technology.[104] Since its inception, the MCHRC has awarded 866 grants totaling $291.7 million, reaching more than 628,000 Maryland residents and leveraging an additional $44.7 million in non-state funding. Grants are subject to robust monitoring and performance evaluation. Grantees submit biannual programmatic and fiscal reports, including deliverable milestones, expenditure details, and narrative updates. The MCHRC also executes special initiatives, such as rural health care delivery planning and technical assistance partnerships with CRISP, the state's designated health information exchange.

### 2. Maryland Health Care Commission (MHCC)

Created in 1999 through the consolidation of two predecessor agencies, the

102. Md. Code Ann., § 19-2101 et seq.
103. https://health.maryland.gov/mchrc/Pages/CHRC-Commissioners.aspx
104. https://health.maryland.gov/mchrc/Pages/notices.aspx

Maryland Health Care Commission (MHCC) is an independent regulatory agency within MDH tasked with health system planning, data analytics, quality reporting, and health information technology advancement.[105] Its statutory purpose is to promote health care access, cost containment, and quality improvement through planning, analysis, and stakeholder engagement.

The MHCC consists of 15 gubernatorially appointed members confirmed by the Senate. Nine members must be unaffiliated with any health care provider or payor; the rest include two physicians, two payors, one nursing home administrator, and one non-physician practitioner. The Governor appoints the chair and the MHCC appoints an Executive Director to manage day-to-day operations.

The MHCC maintains four internal centers: the Center for Health Care Facilities Planning and Development, which administers the State Health Plan and Certificate of Need (CON) program; the Center for Health Information Technology and Innovative Care Delivery, which promotes electronic health records (EHR) adoption and health information exchange; the Center for Analysis and Information Systems, which manages large-scale datasets and maintains transparency initiatives (see, for example, wearthecost.org); and the Center for Quality Measurement and Reporting, which publishes comparative performance data on hospitals, long-term care providers, and health plans.

**Figure 5. Maryland Health Care Commission Organizational Chart[106]**

105.https://mhcc.maryland.gov/#:%7E:text=The%20Maryland%20Health%20Care%20Commission,information%20on%20availability%2C%20cost%2C%20and; Md. Code Ann., § 19-101 et seq.,
106. 2021 Annual Report: Maryland Health Care Commission

The MHCC's core responsibilities include administering the State Health Plan and certificate of need (CON) program, cost and quality reporting, health information exchange coordination, and policy analysis. It also maintains the Medical Care Database, Maryland's APCD, which informs Medicaid rate development and broader payment policy. Additionally, the MHCC oversees electronic health network certification, value-based care initiatives, and consumer-facing transparency tools. The MHCC enforces compliance through regulations and may impose financial penalties of $100 per day or 1% of the approved project budget for violations of reporting rules.[107] The MHCC operates primarily through special fund assessments on hospitals, nursing homes, payors, and health care practitioners, which are capped at $20 million annually.[108] In FY 2025, the MHCC's proposed budget totals $37.85 million.

The agency also administers the Patient Safety Center Fund,[109] which convenes health care providers, patients, and families to improve the quality of health care and reduce preventable and avoidable harm, and MHCC distributes targeted funds such as trauma center relief appropriations under legislative direction.

With respect to public engagement and research publication, the MHCC issues an annual cost and access report to the Governor and General Assembly and releases a wide range of analytic, legislative, and ad hoc reports to inform policymaking. The MHCC also conducts monthly public meetings and posts all agendas and minutes online. It maintains multiple interactive websites that provide accessible information on hospital performance, health plan ratings, and long-term care comparisons.

### 3. Health Services Cost Review Commission (HSCRC)

The Health Services Cost Review Commission (HSCRC) serves as Maryland's hospital rate-setting authority and the cornerstone of the state's unique all-payer model. Operating independently within the Maryland Department of Health, the HSCRC sets hospital-specific rates for inpatient, outpatient, and emergency services and oversees hospital financial performance, quality improvement, and total cost of care accountability.

The HSCRC is composed of seven gubernatorially appointed members, four of whom must have no affiliations with health facilities. Members serve four-year

107. Md. Code of Regs. § 10.24.01.12
108. Md. Code Ann. § 19-111.
109. *Id*. §19-112

terms and are supported by a staff of approximately 50 personnel, led by an Executive Director. Commissioners represent a cross-section of stakeholders, including consumers, payers, and hospital representatives.

The HSCRC has rate-setting authority over 47 acute general hospitals and additional specialty and psychiatric hospitals, collectively accounting for over $16 billion in regulated revenue, including commercial insurer revenue, Medicaid revenue, and Medicare revenue. Rates are established through a transparent methodology designed to ensure that aggregate hospital revenue aligns with reasonable cost structures, while promoting efficiency and equity across payors. HSCRC's all-payer rate-setting policies are grounded in statutory criteria that require cost reasonableness, financial solvency, and equity among purchasers.[110] To support its regulatory work, HSCRC maintains a sophisticated accounting and reporting system and publishes annual Hospital Financial Condition Reports detailing trends in cost per admission, revenue, uncompensated care, and profitability.[111]

The HSCRC also administers a suite of performance-based hospital payment reforms, including: (1) the Maryland Hospital Acquired Conditions (MHAC) program, which imposes financial penalties for preventable complications; (2) the Readmissions Reduction Incentive Program (RRIP), which was implemented to reduce preventable 30-day hospital readmissions in the All-Payer Model and is closely aligned with federal readmissions programs; (3) the Quality-Based Reimbursement (QBR) program, which establishes financial incentives tied to person-centered care and safety measures; and the Potentially Avoidable Utilization (PAU) program, which rewards reductions in unnecessary admissions. Additionally, the HSCRC implements an integrated efficiency policy that adjusts rate structures based on technical efficiency standards and total cost per capita benchmarks, designed to reinforce performance-based payment objectives across hospital settings.[112]

With respect to public engagement and research/analytics publication, the HSCRC holds monthly public meetings and publishes all adopted policies, financial reports, and quality performance metrics online. It coordinates closely with CRISP, the state health information exchange, to facilitate data exchange and quality measure collection, and engages stakeholders through advisory workgroups such as the Performance Measurement Work Group.

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110. https://hscrc.maryland.gov/Documents/pdr/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf.
111. https://hscrc.maryland.gov/Documents/Hospitals/DataReporting/Final%20Hospital%20Financial%20Condition%20Report%20FY%202023.pdf
112. https://hscrc.maryland.gov/Pages/efficiency.aspx

To summarize, Maryland's tripartite regulatory structure combines grantmaking, system planning, rate-setting, and performance oversight performed by three separate subject-matter-specific commissions. Each commission operates independently but is administratively located within MDH and is authorized by statute to coordinate with one another and with MDH. Governance by gubernatorial appointees and strong public engagement practices aim to promote accountability and transparency. Together, these agencies form a comprehensive regulatory framework that integrates funding, oversight, and data infrastructure to advance statewide health system goals. Incorporating elements of Maryland's model – such as dedicated entities with experienced leadership and subject-matter expertise, operating in coordination with other agencies – into Rhode Island's health policy framework could enhance oversight and support long-term sustainability.

## C. Oregon

Health care regulatory authority in Oregon is highly centralized, which appears to have enabled the state to move quickly in exploring innovative and transformative policy reforms aimed at delivering improved care while controlling costs. The Oregon Health Policy Board (OHPB) serves as the centralized policymaking and oversight body for the Oregon Health Authority (OHA). Established in 2009, the OHPB was designed to improve the coherence, accountability, and strategic direction of Oregon's health care governance structure.[113] The OHPB is granted broad rulemaking authority and plays a prominent role in the development and implementation of health policy, with a mandate to improve health outcomes and reduce disparities across Oregon.[114]

The OHPB is a nine-member board appointed by the Governor and confirmed by the state senate.[115] Members serve four-year terms and are paid per diem.[116] OHPB members must possess demonstrated leadership skills and collectively offer expertise in areas such as consumer advocacy, public health, insurance administration, labor, health care delivery, and small business operations.[117]

113. https://www.oregon.gov/oha/OHPB/Pages/index.aspx
114. ORS 413.014;
https://www.oregon.gov/oha/OHPB/MtgDocs/7.%20OHPB%20Priorities%20Governor%27s%20Letter_01.02.24.pdf
115. https://www.oregon.gov/oha/OHPB/Pages/index.aspx
116. ORS 413.006
117. ORS 413.007

**Figure 6. Oregon Health Policy Board – Overview of Governance and Key Responsibilities**

| **Governance** | ***Independent 9-member board*** |
|---|---|
| Board members nominated by the Governor | |

| **Key Responsibilities** | ***OHPB serves as the policy-making and oversight body for the Oregon Health Authority (OHA)*** |
|---|---|

- Develop and submit a plan to the Legislative Assembly to provide and fund access to affordable, quality health care for all Oregonians.
- Develop a program to provide health insurance premium assistance to all low- and moderate-income individuals who are legal residents of Oregon.
- Publish health outcome and quality measure data collected by the Oregon Health Authority
- Establish evidence-based clinical standards and practice guidelines that may be used by providers
- Approve and monitor community-centered health initiatives to improve the health of all Oregonians and regularly report to the legislature on accomplishments and changes needed
- Establish cost containment mechanisms to reduce health care costs
- Ensure that Oregon's health care workforce is sufficient in numbers and training to meet demand
- Establish a health benefit package to be used as a baseline for all health plans offered on the state's insurance exchange (ORS 413.011)

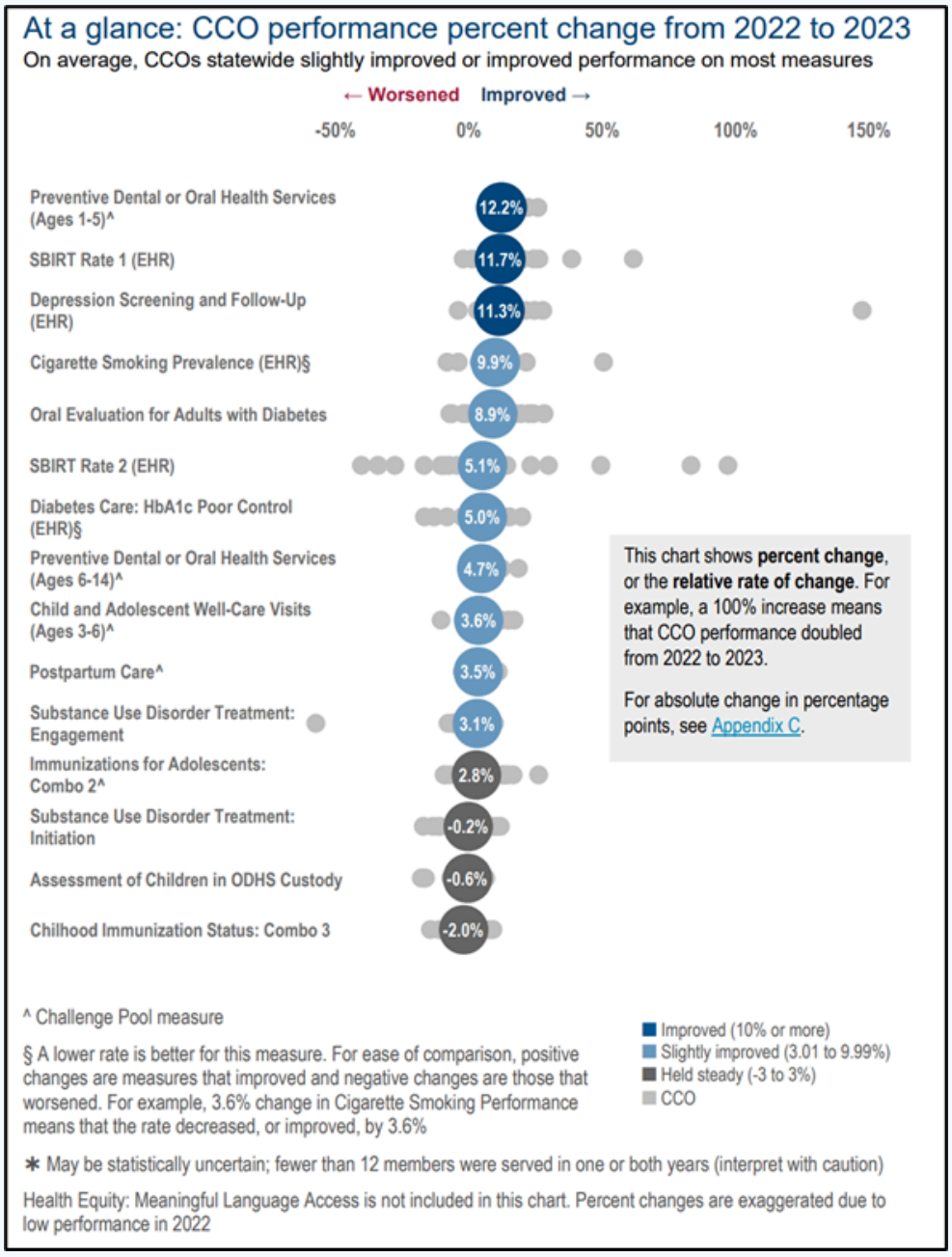
The role of OHPB is intertwined with the OHA, the state's primary administrative agency responsible for health care delivery and financing. OHA oversees Oregon's Medicaid program (the Oregon Health Plan), public health, behavioral health, the Oregon State Hospital, and public employee benefit programs, among others. The OHPB guides OHA's policy development, oversight, and strategic planning, and although the OHPB does not directly administer Medicaid, it provides direction on waiver strategy, spending targets, quality improvement, and long-term vision.

The OHPB is authorized to establish advisory and technical committees to support its work, and coordinates regularly with OHA leadership, the Governor's office, and the legislature to align health system goals. Key advisory committees include the Public Health Benefit Purchasers Committee,[118] Healthcare Workforce Committee,[119] Sustainable Health Care Cost Growth Target Implementation Committee,[120] Medicaid Advisory Committee,[121] and the Primary Care Payment Reform Collaborative.[122]

While the OHPB sets priorities and receives recommendations, the Office of Health Analytics—a division of the Oregon Health Authority—is responsible for managing data systems and performing health system analysis.[123] The Office of Health Analytics supports both the OHPB and state policymakers through the collection and integration of over a dozen data sources, performing analytics related to behavioral health, Medicaid program performance (including Medicaid section 1115 waiver monitoring), hospital finances, workforce data, consumer surveys, quality metrics, equity reporting, and social determinants of health.[124] Figure 4 provides an example of certain health quality measures that the Office of Health Analytics tracks and produces on Oregon Coordinated Care Organizations (CCOs). This analytic capability, embedded within the Oregon Health Authority, is a critical element in enabling data-driven policymaking.

118. ORS 413.017
119. https://www.oregon.gov/oha/HPA/HP-HCW/Pages/index.aspx
120. https://www.oregon.gov/oha/HPA/HP/HCCGBDocs/Approved-Implementation-Committee-Charter.pdf
121. https://www.oregon.gov/oha/HPA/HP-MAC/Pages/index.aspx
122. Primary Care Payment Reform Collaborative, Oregon's Primary Care Transformation Initiative: 2023 Progress Report, at 18, https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2023-PCPRC-Report.pdf
123. https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/index.aspx
124. https://www.oregon.gov/oha/HPA/ANALYTICS/pages/data.aspx

**Figure 4.** [125]




The OHBP oversees key health financing reform initiatives undertaken by Oregon, including establishing a core set of health benefits for Oregon Health Plan Bridge plans, a mechanism by which Oregon has extended health coverage to certain populations. The Oregon Health Plan Bridge program,

125. https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2023-CCO-Metrics-Annual-Report.pdf at 15.

launched in 2024, provides an insurance coverage option designed to enroll people who move on and off Medicaid, transitioning from the Affordable Care Act Marketplace, or people who are otherwise uninsured.[126] The plan provides a comprehensive coverage option with no premium or cost sharing and covers medical, dental, and behavioral health for individuals with incomes up to 200% of the Federal Poverty Line (FPL).[127] The Oregon Health Authority appoints members to the Oregon Health Plan Bridge Advisory Committee, which provides recommendations on plan benefits and operations.[128] The Bridge Program provides a coverage option for a population most likely to forgo coverage, thus providing a pathway for affordable health care access to a vulnerable subset of the population.[129]

The health care regulatory structure used in Oregon provides a useful foundation for potential application in Rhode Island. Oregon uses an independent Board (OHBP) to oversee the state's technical regulator (OHA). This structure allows OHBP to provide directional policy input and make strategic decisions about priorities for reform, resource allocation, and investment decisions, decisions that then undergo further technical development and implementation by the OHA. Oregon has been able to effectively use this regulatory structure to achieve meaningful health care financing reforms, including the introduction of Oregon Bridge, a state administered, publicly funded insurance option designed to close coverage gaps and provide an affordable alternative to private insurance.

## D. Vermont

While Vermont faces a host of unique affordability, provider consolidation, and access-to-care barriers, it serves as yet another example of a state that has largely centralized its health care regulatory authority, allowing the state to be more responsive to the state's unique cost and access pressures. Vermont's Green Mountain Care Board (GMCB) serves as Vermont's independent health care regulatory and policymaking body, with a mission to drive statewide improvements in health care access, affordability, and quality.[130] Created in

126.https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284054
127. *Id*.
128. https://www.oregon.gov/oha/hsd/ohp/pages/obac.aspx
129.https://olis.oregonlegislature.gov/liz/2023I1/Downloads/CommitteeMeetingDocument/284054
130. https://gmcboard.vermont.gov/board

2011, the GMCB is one of the most comprehensive health regulatory agencies at the state-level in terms of its breadth and statutory authority. The Board has a number of specific duties that are intended support its mission,[131] and it holds extensive authority over health system regulation, cost containment, and innovation in payment and delivery reforms.[132] Though GMCB does not directly administer the state's Medicaid program, its co-leadership of the Vermont All-Payor Model and budget oversight of ACOs provide it with substantial influence over health system policy and funding.

**Figure 8. Vermont Green Mountain Care Board – Governance and Key Responsibilities**

| **Governance** | ***Independent 5-member board*** |
|---|---|
| Chair and all members are nominated by Green Mountain Care Board Nominating Committee; members are ultimately appointed by the Governor and confirmed by the Senate. | |

| **Key Responsibilities** | ***The GMCB conducts oversight with a data-driven, system-wide view to improve access, affordability and quality of care.*** |
|---|---|

- Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs
- Implement methodologies for achieving payment reform and containing costs through global budgets, bundled payments, and other payment methodologies that may integrate Medicare and Medicaid.
- Work in collaboration with providers to develop payment models that preserve access to care and quality in each community.
- Payment reform methodologies developed by the Board shall encourage coordination and planning on a regional basis, taking account of existing local relationships.
- Set provider payment rates, including hospital budgets, and approve/disapprove health insurance rate requests.
- Review and approve/deny applications for certificates of need.
- Report to the legislature on proposed payment methodologies
- Publish the Health Resource Allocation Plan identifying Vermont's critical health needs, goods, services, and resources
- Review and approve the Health Care Workforce Development Strategic Plan.
- Develop and maintain a method for evaluating systemwide performance and quality (18 V.S.A. § 9375.)

131. 18 V.S.A. § 9375.
132. 18 V.S.A. § 9372.

The GMCB is composed of five members appointed by the Governor for staggered six-year terms. Appointments are made through a nine-member nominating committee made up of legislators and gubernatorial designees with expertise in health care policy, delivery, or financing, helping[133] to ensure independence and diversity of expertise. Board members receive compensation and are supported by a staff of approximately 25 professionals.

The GMCB maintains several formal advisory groups to support its policymaking, including the General Advisory Committee, the Primary Care Advisory Group, the Prescription Drug Technical Advisory Group, and the Data Governance Council.[134] Each of these bodies assists the Board by providing stakeholder-informed recommendations on issues such as clinical policy, prescription drug pricing, and data stewardship.

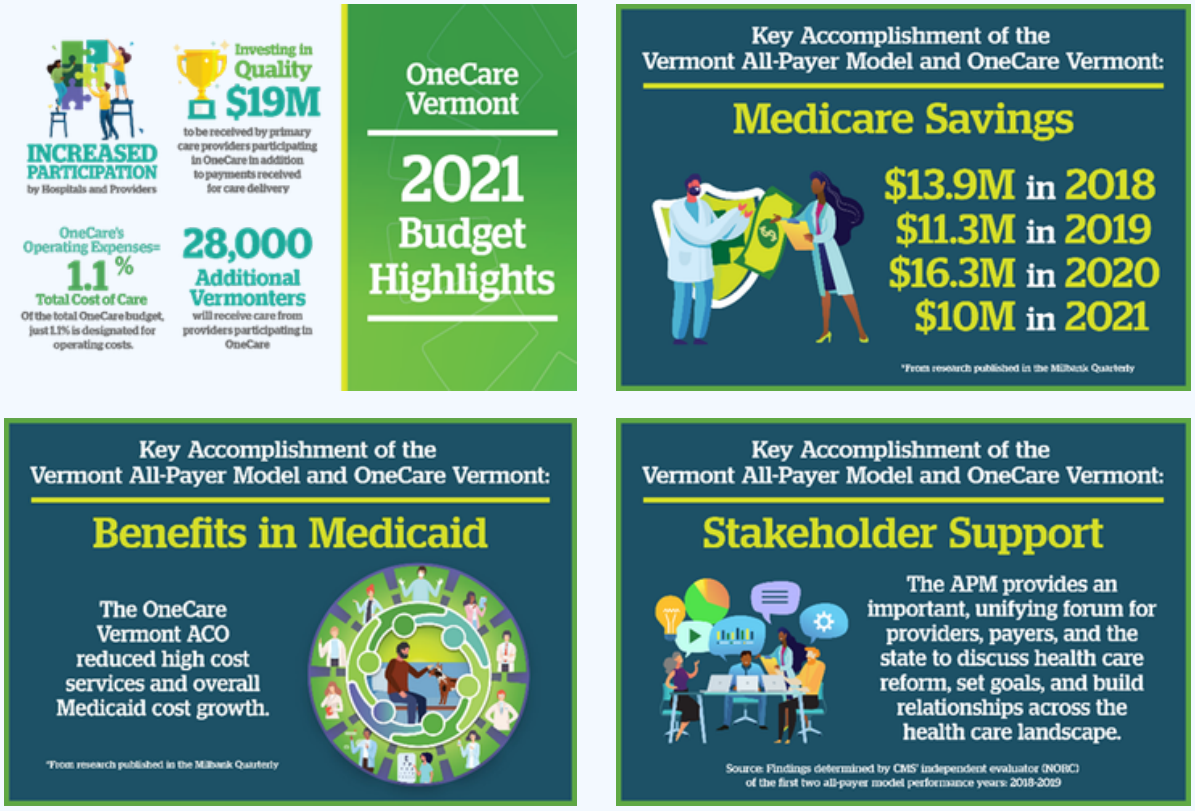
Operations are funded through a combination of general funds and assessments levied on regulated health care entities, including a 30% assessment on hospitals, 24% assessment on insurers and health maintenance organizations, and 6% assessment on ACOs.[135] The GMCB's total FY 2025 proposed budget was $8.8 million.[136]

The GMCB exercises broad regulatory authority across Vermont's health care system. It oversees hospital budget approvals, health insurance rate review, the certificate of need (CON) process, ACO certification and budget review, and review and approval of health resource allocation plans, standardized insurance benefit packages, and workforce development strategies.[137]

The GMCB also plays a central role in shaping the trajectory of Vermont's health care system through regulatory oversight and innovative policy initiatives. It oversees Vermont's All-Payer Accountable Care Organization Model, a multi-payer arrangement launched in 2018 and extended through 2024, which merges numerous payor sources into a single payment system that operates statewide through an ACO (OneCare Vermont).[138] The Board monitors ACO performance, certifies ACOs, and conducts budget reviews to ensure consistency with the All-Payor Model goals (see Figure 9).

133. 18 V.S.A. § 9390.
134. https://gmcboard.vermont.gov/content/gmcb-committees
135. https://finance.vermont.gov/content/fy2024
136. https://finance.vermont.gov/content/fy2025
137. 18 V.S.A. § 9382
138. https://gmcboard.vermont.gov/sites/gmcb/files/documents/APM_Summary_20230201.pdf; https://gmcboard.vermont.gov/aco-oversight/FY25OneCareVermont

**Figure 9. Vermont All-Payer Model and OneCare – Progress on Key Metrics[139]**




The GMCB's analytics team produces public reports analyzing trends in health care costs, insurance coverage, service utilization, and quality. The Board's statutory duties include maintaining uniform hospital and insurer data sets to evaluate expenditures, workforce, and access.[140] The GMCB also publishes a comprehensive Health Resource Allocation Plan, identifying critical statewide needs, available services, gaps in care, and strategic priorities for investment.[141]

Like the earlier-mentioned state health regulatory bodies, the GMCB holds meetings open to the public, and its reports and summaries are posted online in accordance with its statutory obligations, which also require the Board to

139. https://www.onecarevt.org/news/2021-budget-present/; https://x.com/OnecareVermont (Oct. 11, 2023); https://x.com/OnecareVermont (Jan. 17, 2023); https://x.com/OnecareVermont (Dec. 28, 2022).
140. 18 V.S.A. §§ 9405, 9410, 9453, and 9454.
141. https://gmcboard.vermont.gov/health-resource-allocation-plan

to provide avenues for public comment, including written submissions and public hearings.[142]

Under 18 V.S.A. § 9380, the GMCB has the authority to adopt rules necessary to carry out its statutory duties. The Chair may issue subpoenas, compel testimony, and require production of documents. Administrative penalties of up to $2,000 per day may be imposed for noncompliance. For example, in FY 2017, the Board imposed provisional conditions on the University of Vermont Medical Center's use of surplus funds to ensure investment in inpatient mental health infrastructure.[143] These tools enable the Board to flexibly tailor regulatory requirements to achieve its cost containment and quality improvement mandates. Vermont's approach to structuring its health care regulatory authority provides a strong example of centralized, transparent, and data-driven regulation aimed at improving health system performance.

Vermont's GMCB has produced tangible benefits for the people of Vermont. Most recently, for Plan Year 2026, the GMCB saved Vermonters $11.4 million in premiums.[144] The GMCB has the authority to review hospital spending in Vermont to ensure Vermonters have access to quality and affordable health care while guarding the financial stability of its hospitals.[145] It reviews and approves hospital budgets while applying a stringent standard: "overall health care costs must be contained, and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care."[146] This mechanism allows the GMBC to keep the health care system financially stable, while pursuing its goal of ensuring care is affordable for Vermonters. In 2023, the GMCB found that four hospitals deviated from their approved budgets, allowing it to apply corrective measures, including reducing future commercial rates for two years for at least two of the hospitals.[147] This system of hospital budget and rate reviews has allowed Vermont to think strategically about how money is invested into the health care system to help ensure that quality care is kept affordable and its health system is stable.

142. 18 V.S.A. § 9378
143. https://gmcboard.vermont.gov/Hospital-Budget-Enforcement/FY2017
144.https://gmcboard.vermont.gov/sites/gmcb/files/documents/2024%20GMCB%20Annual%20Report%20-%2001.15.2025%28A%29.pdf Page 11
145. *Id*. at 14.
146. *Id*.
147. *Id*.

While Rhode Island's existing challenges and health regulatory structure require a state-specific approach that cannot be adopted wholesale from other states, these examples from other states present a set of common regulatory features that have proven to be successful in other parts of the country. The experiences of states, such as Massachusetts, Maryland, Oregon, and Vermont, demonstrate that effective health system governance requires a clearly defined agency mandate to prioritize long-term planning and sustainability, centralized decision-making and innovation on health care financing, strong in-house data/analytic capacity, and leadership structures that promote accountability and responsiveness to population needs.

# III. Reorganizing EOHHS and Establishing the Office of Health Policy and Planning to Advance Sustainable Reforms

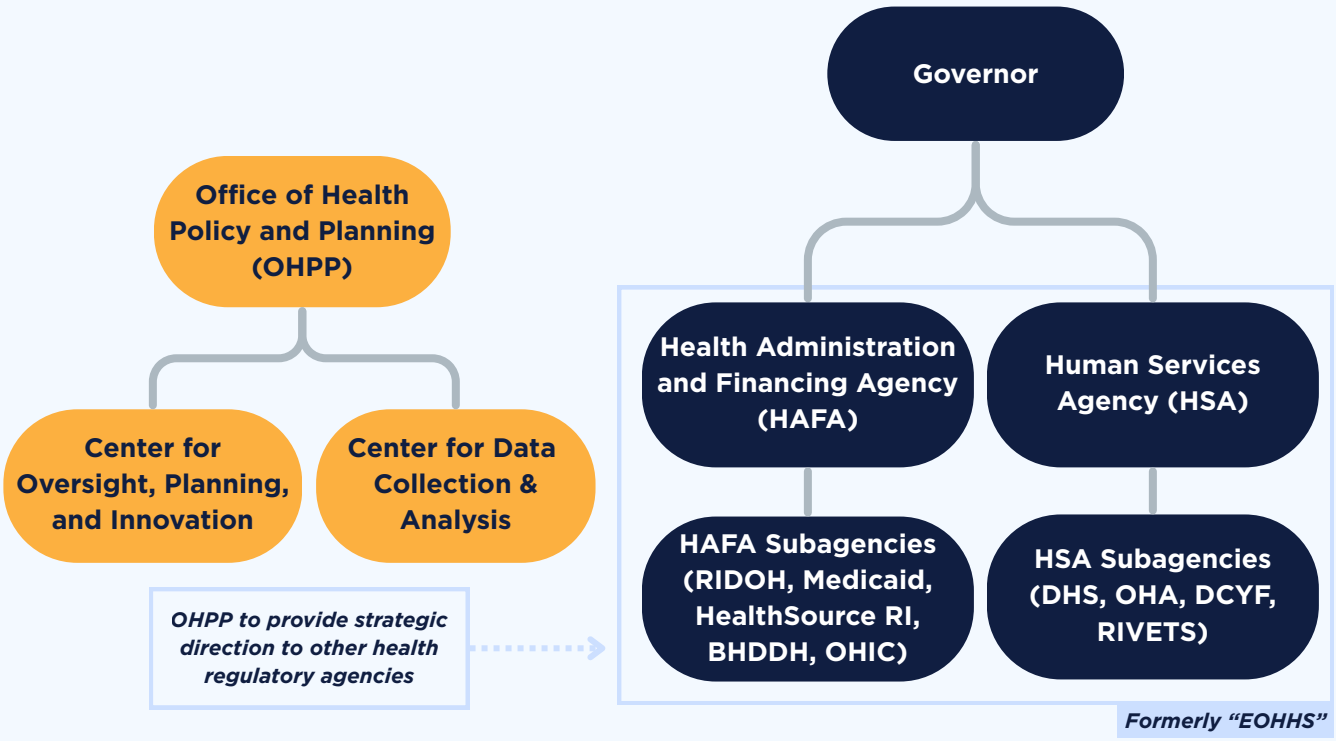
Drawing on feedback shared by stakeholders, including health care professionals across the State, and informed by this Office's direct experience working within the current health care environment, we propose two overarching reforms that will modernize and strengthen Rhode Island's health care regulatory system:

**(1) Establish the new Office of Health Policy and Planning (OHPP)** to lead system-level reform efforts, serve as a hub for data collection and analysis, and engage in health planning activities that drive coordinated, evidenced-based change throughout the state's health system.

**(2) Reorganize the Executive Office of Health & Human Services (EOHHS)** to give more focus, accountability, and resources to the state's existing health regulatory infrastructure. This includes dividing EOHHS into two cabinet-level agencies – the Health Administration and Financing Agency (HAFA) and the Human Services Agency (HSA) – and administratively transferring certain health regulatory agencies currently assigned to other cabinet level agencies (OHIC and HealthSource RI) to HAFA. Through more clearly defined statutory authorities, each agency will assume certain technical functions currently performed by state regulators, enabling more streamlined operations and enhanced oversight aligned with each agency's respective mission.

These two organizational reforms are closely interconnected. To ensure consistent, prudent, and long-term policy that meets the needs of Rhode Island residents, OHPP will leverage its analytic and policy expertise to set the strategic direction for the state's health system. It will also review, approve, modify, or deny material regulatory decisions that implicate system performance goals. At the same time, HAFA and HSA will carry out their statutorily assigned responsibilities in a manner that furthers the objectives set by OHPP, ensuring that policy decisions are aligned with OHPP's strategic plan (see Figure 10). Given OHPP's role as the strategic leader and coordinator of the Rhode Island's health system, we begin by outlining OHPP's mission, legal authority, and core functions, followed by a description of how HAFA and HSA will operate within this updated governance framework.

**Figure 10. Proposed Agency Restructure**



## A. Creation of the Office of Health Policy and Planning (OHPP)

As detailed above, Rhode Island's health care system lacks coordinated, data-driven, and system-wide regulatory oversight. Meanwhile, the State is confronting numerous ongoing crises that demand a more unified and strategic response. Mounting federal budgetary pressures – including the enactment of the Trump Administration's H.R. 1[148] – have only accelerated the need for comprehensive structural reform. Yet, too often, policymakers and regulators tasked with critical decision-making lack access to necessary data and information, or must resort to external consultants to fill information gaps. This is not only inefficient, given the high fixed costs of producing workable datasets, but it leaves regulators unable to fully access and leverage data for new future use cases.

Equally concerning, without sufficient data analysis capacity, major investment decisions are made without clear plans to monitor and track performance, leaving regulators uncertain about which policies are actually effective. Data is a vital source of legitimacy for new policies; likewise, the lack of such data analysis and program evaluation can cast doubt on effective policies, potentially leading legislators to reject certain investments or allow programs to sunset or go unrenewed. This further drives instability and increases administrative costs to the system. Achieving the structural reforms Rhode Island needs depends on the ability to access reliable, accurate and timely data about financial and operational system performance, access to care, and population health outcomes.

To address Rhode Island's unmet needs, we propose the establishment of the Office of Health Policy and Planning (OHPP). The mission of OHPP will be to ensure the immediate and long-term success of Rhode Island's health care system by centralizing health data collection and analysis, performing comprehensive health system planning, and formulating and advancing policies that support affordability, access, and quality. As detailed in Figure 11, OHPP will serve as Rhode Island's central hub for health system data, strategic planning, and coordinated action on health care policy matters, enabling the State to make strategic and sustainable investments in its health system.

148. Public Law No: 119-21.

**Figure 11. Office of Health Policy and Planning (OHPP)**

**OHPP will serve the public interest by equipping state leaders, regulators, and stakeholders with reliable, timely, and actionable information about Rhode Island's health care markets and systems.**

Through independent governance, transparent reporting, expertise in data and health planning, and a steadfast commitment to equity, **OHPP will uphold public accountability while guiding informed decisions about patients' needs, the broader health system, and the policies required to meet those needs effectively.**

The **specific goals** of the Office of Health Policy and Planning include:

- Serving as the centralized hub for health system data collection, analysis, and long-term planning in Rhode Island;
- Expanding access to high-quality, affordable, evidence-based health care for all Rhode Islanders;
- Promoting quality, safety, efficiency, and equity in health care delivery and coverage;
- Establishing innovative payment and financing methodologies that put Rhode Island's health care system on the path to sustainable cost control;
- Researching and advancing reforms built around the determinants of health;
- Supporting health workforce expansion and retention through targeted policy development and strategic investment; and
- Advancing transparency and accountability through robust reporting and meaningful stakeholder engagement.

### 1. Legal Authorities and Duties

Rhode Island's current landscape suffers from fragmented regulatory functions, with no single agency empowered to evaluate systemwide performance or align capital and operational investments with a unified, long-term plan. OHPP is designed to address these deficiencies by consolidating and modernizing several key health planning and oversight functions which are currently dispersed across multiple state agencies:

- **Health Data Repository:** OHPP will serve as the State's data steward, managing a consolidated repository of health system data, including the All-Payer Claims Database (APCD) and the Ecosystem data platform. OHPP will also design and implement new data collection strategies and modernize data reporting processes to improve the quality, timeliness, and usability of health data. OHPP will have the authority to levy fines on entities that fail to respond to information requests.

- **Policy Analysis and Reporting:** OHPP will be responsible for publishing regular and ad hoc reports on key system indicators, such as cost, access, quality, and market structure. It will also conduct special analyses at the request of other executive branch agencies, the Office of the Attorney General, and the General Assembly, to support evidence-based policymaking.
- **Comprehensive Health System Plan:** OHPP will develop and maintain the State's long-term health system plan, which will serve as the strategic framework for aligning investments in health care facilities, workforce development, and technology. infrastructure. This Comprehensive Health System Plan will serve as a single, unified guide for decision-making and regulation by OHPP and other health agencies.
- **Financial Oversight of Health Care Facilities:** OHPP will monitor and report on the financial condition of health care institutions across the State, identifying risks to continuity of care and enabling timely, proactive intervention to ensure sustainable operations.
- **Hospital Conversions and Capital Expenditure Review:** OHPP will assume RIDOH's current role in reviewing hospital conversions, in coordination with the Office of the Attorney General. OHPP will also be tasked with reforming and administering the Determination of Need (DON) process to ensure that proposed expansions and services align with the State's health system plan.
- **Intergovernmental Coordination:** OHPP will serve as Rhode Island's lead for coordinating with other states and the federal government on waiver applications, regional public health and health policy initiatives, and other multijurisdictional regulatory efforts.

**2. Governance, Personnel Structure, and Funding**

To ensure independence and public accountability, OHPP will be housed within the newly reconstituted Health Administration and Financing Agency (formerly EOHHS) for administrative purposes only. It will operate as a standalone, independent regulatory agency, not under the control, direction or supervision of any other executive branch department or agency.

OHPP will be governed by an independent Board of Directors comprised of seven members: Two of the members shall be appointed by the Governor. The Attorney General shall submit to the Governor a list of candidates, to which the Governor shall give due consideration in selecting two members. The Speaker of the House and the Senate President shall each submit a list of candidates to the Governor, which the Governor shall give due consideration to in selecting two members. The final member shall be the Secretary of the Health Administration and Financing Agency (HAFA), sitting ex officio as a voting

member. The Executive Director of OHPP shall oversee the administrative affairs and general administration of the Board and shall serve as the Secretary of the Board, in a nonvoting ex officio capacity.

To be eligible for appointment, a prospective board member must have significant experience (10+ years or relevant terminal degree) in public health research, program development and implementation, or policy development and implementation; health care data analytics, data science, or biostatistics; health systems or insurance administration; or health care financial management, health economics, or experience implementing innovative payment models. Any appointed member of the Board must also be free of conflicts of interest and have a proven track record of commitment to improving health care delivery, accessibility, affordability, and equity.

Led by an Executive Director appointed by the Board, OHPP will be supported by two centers: the Center for Data Collection & Analysis (CDCA) and the Center for Oversight, Planning, and Innovation (COPI). Each center will be led by a Deputy Director and include teams responsible for carrying out the agency's core work in data, policy, and planning. Together, and in coordination with HAFA, these centers will ensure that OHPP's efforts are informed by evidence-based research, strategic oversight, and innovative planning to ensure that the State can sustainably deliver high-quality, affordable health care to all Rhode Islanders.

As discussed in more detail in Section IV, OHPP's operations will be supported through a combination of general fund appropriations and assessments on regulated entities. Establishing a structured and reliable funding stream—modeled after similar approaches adopted elsewhere, such as Massachusetts' Health Policy Commission, Maryland's Health Care Commission, Oregon's Health Policy Board, and Vermont's Green Mountain Care Board—will promote independence and consistency across budget cycles.

**3. Key Functions of OHPP Centers**

*i. Center for Data Collection & Analysis (CDCA)*

The Center for Data Collection and Analysis (CDCA) will serve as Rhode Island's single health data and analytics center, responsible for administering the state's All-Payer Claims Database (APCD) and Ecosystem platform, integrating health datasets, and producing timely analytics to support regulation and policy. CDCA's integration of data sources will provide consistent and reliable data reporting on spending, utilization, quality, and health equity. The center will design information collections to inform key

policy goals and will monitor compliance and enforce information collection requirements, using remedies such as fines and specific performance directives when necessary. To ensure that CDCA's information collection authority is comprehensive and cannot be circumvented through vendor relationships, management services organizations, or other intercompany financial relationships, CDCA should be authorized to impose information-reporting obligations on entities that are affiliated with, commonly owned with, hold an ownership or partnership interest in, or exercise managerial control over a health care entity in Rhode Island.

A primary goal of OHPP's creation is to increase and centralize accessible data on Rhode Island's health care system performance. To support this, CDCA will collect financial, operational, and demographic data directly from provider organizations and insurers – including payment amounts, cost information, quality and access-to-care surveys, uncompensated care, discharge volumes, payor mix, and ownership/affiliation information – and use it for analytical and public-reporting activities. To promote transparency and consistency in reporting, CDCA will be required to publish an annual report, tracking key aspects of health system performance, special topics of interest and policy recommendations.

The CDCA will have statutory access to all relevant health data maintained by any State agency, uphold the highest standards of data privacy and security, and provide public guidance regarding the handling of sensitive health information. This cross-organizational collaboration and information sharing is vital to promote the state's objectives. For example, CDCA should establish a process for responding to data requests from HAFA, the General Assembly, the Office of the Attorney General, other agencies, and private researchers, ensuring its data infrastructure supports decision-making throughout the State.

*ii. Center for Oversight, Planning, and Innovation (COPI)*

The Center for Health System Oversight, Planning, and Innovation (COPI) will be responsible for long-term planning, performance oversight, regulatory coordination, and policy innovation. The center's work will include developing health policies to improve health outcomes, identifying and supporting funding and investment targets to improve access to care and promote high-value care, and controlling health care costs and insurance premiums.

A key function of COPI will be developing and maintaining the State's Comprehensive Health System Plan, which will outline long-term performance targets related to access, quality of care, spending, and facility and provider

financial health. Although Rhode Island has recently sought to strengthen health system planning,[149] its current planning capacity is limited and lags behind other states. As a model, in 2025, Massachusetts established a dedicated health planning function within the HPC, requiring the agency to: anticipate the state's needs for providers, programs, and facilities, identify existing and projected resources (including workforce enhancements) required to meet needs; make recommendations on appropriate, supply, distribution, and prioritization of resources; and identify state actions to implement the state plan's recommendations.[150] A similar framework should be used by COPI.

In addition to creating and maintaining the State's health system plan, COPI will set cost growth and rate caps, and establish spending targets for insurers and health systems, with authority to enforce these targets against regulated entities or to impose performance improvement requirements on entities. In collaboration with CDCA's data intake function, COPI will also monitor regular financial data reporting by health care facilities to identify concerning trends and take proactive steps to promote financial stability and avoid disruptions in access to care.

COPI will also perform key functions with respect to market oversight, including monitoring major transactions involving health providers. These functions will include:

- **Reviewing Hospital Conversions and Changes in Effective Control.** In coordination with the Office of the Attorney General (RIAG), COPI will review and make determinations and recommendations regarding hospital conversions and changes in effective control (CEC). Transitioning these functions to COPI ensures that decisions are informed by agencies with the expertise, data access, and analytical capacity necessary to perform a thorough review of each proposed transaction. In reviewing such transactions, COPI will closely scrutinize changes of control that could create long-term financial risks, either denying applications, imposing strict conditions, or adopting creative strategies to support existing facilities so that they can continue to operate and serve the needs of Rhode Islanders without being acquired. COPI's role in reviewing transactions should also be integrated into OHPP's Comprehensive Health System Plan, which should proactively outline transaction-related priorities, areas for concern, and safeguards or conditions that transacting parties may presumptively be required to implement if transactions exhibit certain risk factors.

149. https://eohhs.ri.gov/RI-Health-Care-System-Planning
150. https://masshpc.gov/offices-and-task-forces/ohrp;
https://malegislature.gov/Laws/SessionLaws/Acts/2024/Chapter343

- **Reviewing Capital Investments, Monitoring Financial Stability, and Upholding Community Benefit and Charity Care Standards.** COPI will administer a reformed Determination of Need (DON) process, oversee facility financial health, and monitor community benefit and charity care compliance. These financial aspects of health organization operations are best housed in an agency with health system planning expertise, enabling RIDOH to concentrate on its mission-critical public health and safety functions. Historically, the DON process in Rhode Island has been excessively siloed, has lacked the necessary rigor to assess the costs and benefits of certain investments, and has faced the twin risks of regulatory capture and protectionism by entrenched interests.[151] With respect to the DON process, COPI will lead the development of a reformed DON process and propose implementing legislation to codify these reforms. The reformed DON process should be structured to ensure that new capital investments are in line with the State's Comprehensive Health System Plan and are reviewed with a view toward health equity implications. Until new DON legislation is enacted, RIDOH will continue to administer the DON process but will be required to provide a recommendation to, and obtain approval from, the Executive Director of OHPP, prior to approving or denying a DON application.
- **Reviewing "Material Change" Transactions.** COPI will also coordinate with RIAG to review material change notices submitted by health care entities engaging in acquisitions, mergers, or other significant transactions involving medical practice groups.[152] Similar to the process used in Massachusetts, COPI will be given authority to identify potentially anticompetitive transactions and perform a searching market impact assessment of such transactions to further ascertain and quantify the extent of anticompetitive effects. COPI will assess impacts on access, quality of care, facility finances, health care costs, and health equity, guided by the State's comprehensive health system plan. The center should be authorized to make recommendations and referrals to RIAG on anticompetitive risks so that RIAG can take appropriate legal action to investigate, block, or place robust conditions on potentially anticompetitive transactions.
- **Participating in Health Insurance Rate Review.** With respect to its responsibility to ensure affordability of care, COPI will have statutory authority to participate in OHIC's health insurance rate review process, advocating on behalf of Rhode Island consumers and assessing whether

151. In 2026, the Legislature modified the DON process to address historical challenges; these amendments provide a strong starting point for COPI to work from in pursuing any future reforms to the DON process.
152. 110-RICR-30-00-5.

proposed rates align with the Comprehensive Health System Plan. Thisresponsibility would be transitioned from RIAG to COPI, and COPI will be authorized to use in-house or contracted experts during rate review hearings.[153] While OHIC will retain final authority to approve, deny, or modify proposed rate increases, implementing legislation should ensure that COPI's findings and recommendations are given significant weight in the rate review process.

- **Leveraging Federal Waivers to Innovate and Tailor Programs to Local Priorities.** COPI will lead the design and implementation of innovative Medicaid, Medicare, and ACA waiver initiatives in partnership with Medicaid and HealthSource RI. There are numerous federal waiver programs available to states, subject to federal approval. For example, Medicaid section 1115 waivers grant states the flexibility to test new delivery models that expand coverage or benefits to new health care services, modify existing delivery systems or introduce alternative payment models that tie reimbursement to value and quality of care.[154] ACA section 1332 waivers provide similar flexibilities in state insurance exchanges,[155] and Medicare section 1115A demonstration projects can provide states with expanded control over Medicare payments.[156] The processes for designing and seeking approval of these waivers is time and resource intensive, and requires significant regulatory engagement with the Centers for Medicare & Medicaid Services (CMS) to secure waiver approval. COPI will be authorized to lead these efforts, promoting innovation and ensuring waivers are consistent with the Comprehensive Health System Plan. OHPP will also be required to establish rigorous methods to test and monitor waiver performance, ensuring objectives are met or recommending policy adjustments when outcomes fall short.
- **Coordinating Health Policy with Neighboring States and Building Stakeholder Feedback into Policy Creation.** State-level health policy making often intersects with policies in neighboring states, yet Rhode Island's current regulatory structures rarely account for these inter-state effects. COPI and OHPP's leadership team will coordinate with neighboring states to develop cooperative regional policies that pool resources to solve impending health / financial threats and mitigate harmful, often unintended, externalities created by each state's endemic policies. COPI will build on existing Northeast regional efforts initiated in response to federal threats on

153. The Massachusetts Office of Patient Protection, within the Health Policy Commission, serves as one potential model for incorporating consumer representation in health insurance matters into OHPP.
154. Social Security Act, § 1115.
155. Affordable Care Act, § 1332.
156. Social Security Act, § 1115A.

public health.[157] Additionally, COPI will be charged with convening an annual statewide health policy forum—including perspectives of patients, community organizations, providers, employers, unions, and insurers—to gauge the extent to which its policy focus is aligned with community needs and develop consensus community recommendations on policies aimed at improving the health system. COPI will take steps to ensure that participants at the statewide health policy forum represent the full diversity of the Rhode Islanders who rely on our health care system, including members of racial, ethnic, and sexual and gender minorities, as well as members from historically marginalized communities.

**4. Closing Rhode Island's Health System Regulatory Gaps**

Establishing the Office of Health Policy and Planning will address known shortcomings, including those identified in the Rhode Island Foundation's 2023 report and the 2022 Special Legislative Commission's report:

- **Reducing Fragmentation.** Oversight functions are currently fragmented across multiple agencies—including OHIC, EOHHS, RIDOH, and RIAG—without a single entity responsible for health system planning or oversight. OHPP will fill this gap with a centralized structure and a clear mandate.
- **Data Focus.** Prior reports highlight the urgent need for centralized data stewardship. OHPP will address this by creating a single authoritative source for health care data and analytics.
- **Planning Focus.** Rhode Island's health care system has suffered from a lack of coherent health system planning. Without a comprehensive health system plan, the State cannot effectively align investments, manage costs, and prevent crises and costly bailouts. OHPP will institutionalize health system planning, as a recurring, consensus-driven process that prioritizes allocation of resources and informs policy decisions. This proposal aligns with existing reform measures recently adopted in Massachusetts to strengthen the Commonwealth's health planning infrastructure.
- **Independence and Accountability.** Existing agencies lack coordinated authority to evaluate and respond to health system challenges holistically. OHPP will provide the authority, accountability, and staffing necessary to fill these regulatory gaps.

157. https://www.ri.gov/press/view/49762

By pursuing more proactive oversight and policymaking, Rhode Island will be able to move away from its reactive posture—taking regulatory action only after crises materialize or failing to foresee predictable negative impacts resulting from health care transactions. OHPP's analytic and planning functions will serve as effective early-warning systems and shift the State to a preventive and strategic model for health system regulation.

## B. Reorganization of EOHHS and Existing Health Agencies

Building on OHPP's role in centralizing data, coordinating health system planning, and providing proactive oversight and regulation, it is equally important to align the remaining facets of the state's administrative structure to support these functions. To promote greater efficiency, accountability, and coordination across the health and human services system, this white paper proposes the elimination of the existing Executive Office of Health and Human Services (EOHHS) and its reorganization into two cabinet-level agencies: the Health Administration and Financing Agency (HAFA) and the Human Services Agency (HSA). In tandem with this reorganization, health regulatory functions currently disseminated throughout other cabinet level agencies will be centralized within HAFA.

A key goal with this reorganization is to achieve a tighter grouping of agencies by subject matter. Assigning health system-related functions to one specialized agency (HAFA) and human services programs to another (HSA) will help deepen expertise in each respective area, eliminate regulatory gaps or opportunities for inaction, and ensure proper leadership/oversight of the respective agencies.

It is important to note that this restructuring does not deprioritize existing functions; rather, it elevates existing public health and welfare responsibilities pursued by regulators within EOHHS and its subagencies by providing greater support, resources, and focus to carry out their core functions in accordance with system-level policy mandates. By allocating broad strategic policy authority to OHPP and refocusing the existing agencies' on their core regulatory functions, all agencies can specialize and develop talent to perform their respective tasks, there will be greater accountability for long-term policy priorities, and the state can expand its capacity for health system planning,

policy innovation, and data collection and analysis. With this reform, regulators currently within EOHHS agencies (e.g., RIDOH, the Medicaid agency, and BHDDH) will be better positioned to perform, and expand upon, their vital technical, implementation-oriented work.

This redesigned structure will share similar features to regulatory approaches adopted in other states but will streamline oversight, strengthen policy implementation, and ensure focused leadership in both health system governance and human services delivery. The regulatory expertise and oversight functions needed with respect to Rhode Island's health care system are sufficiently distinct from oversight of Rhode Island's human services system. Establishing separate cabinet level secretaries for each system will enhance talent acquisition and workload capacity, without sacrificing inter-agency collaboration. Allocating separate regulatory responsibilities over each system will also enable greater specialization and clearer accountability at the cabinet level. Finally, implementing this reorganization in tandem with establishment of OHPP will reduce the potential for actual or perceived friction between regulatory authorities and allow the newly structured agencies to reorient and collaborate around each agency's respective roles.

**Figure 12. Existing EOHHS Structure**

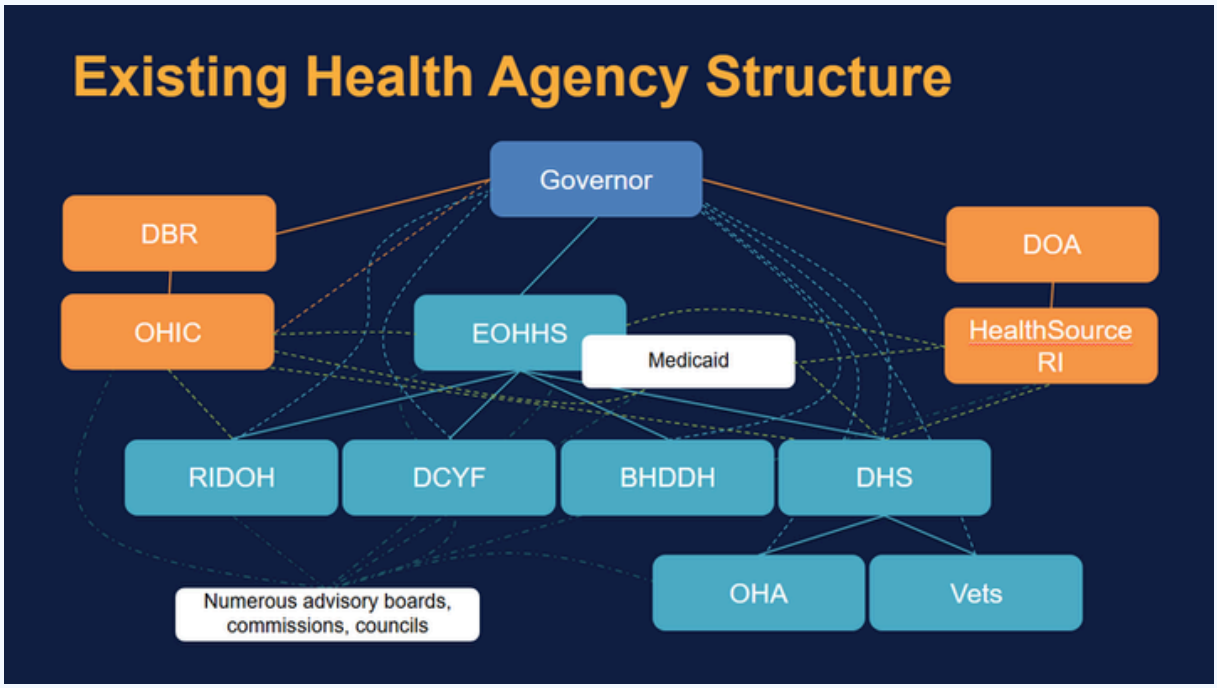
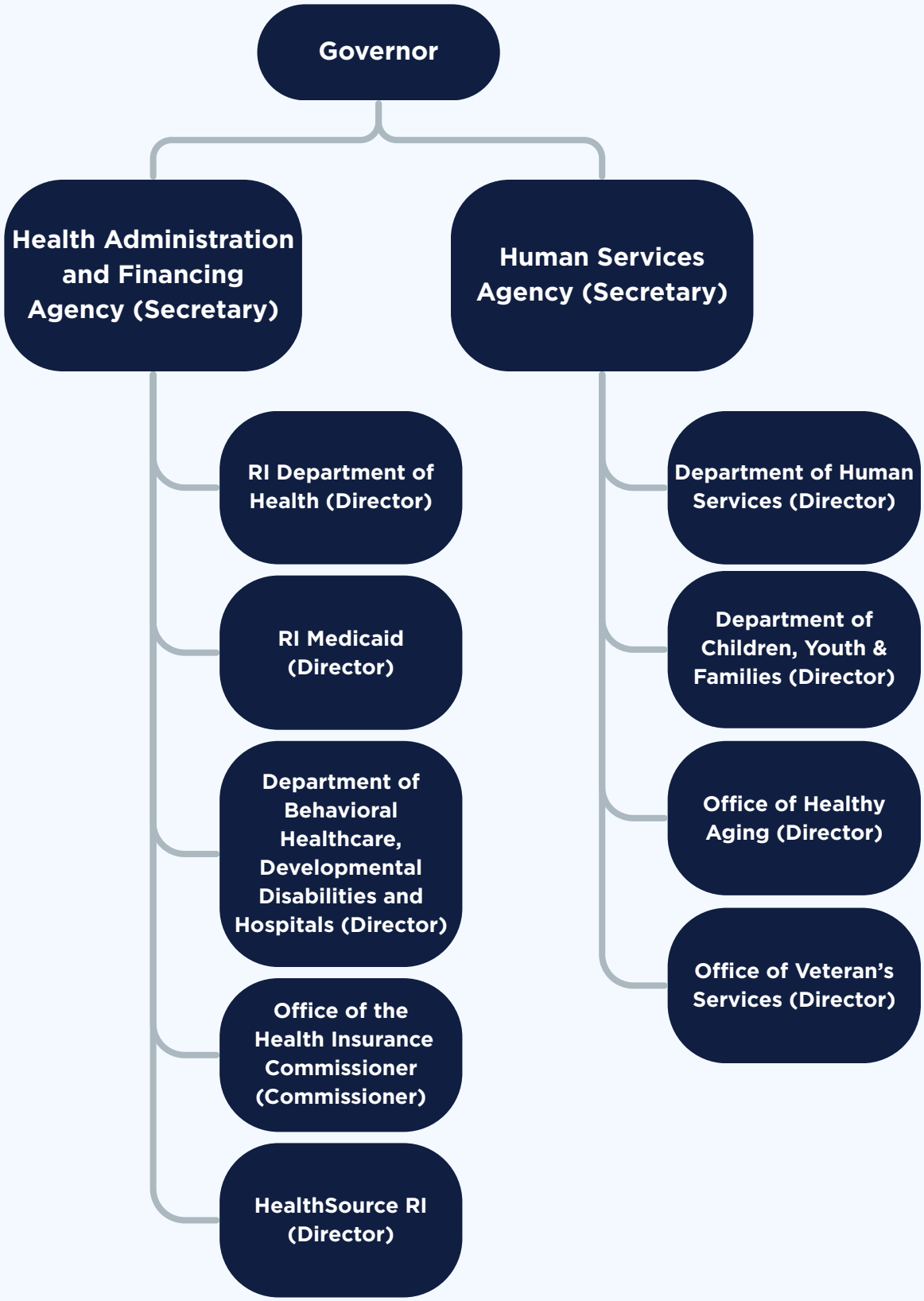


**Figure 13. Reorganization of Existing EOHHS Structure**

Proposed Structure



### 1. Health Administration and Financing Agency

The Health Administration and Financing Agency (HAFA) will serve as the centralized executive agency responsible for all health system regulatory functions not assigned to the newly proposed Office of Health Policy and Planning. The Secretary of HAFA, appointed by the Governor with the advice and consent of the Senate, will serve as the chief administrative officer for all sub-agencies and departments under HAFA, with clear accountability for performance and management.

The following departments will be housed within HAFA, with subagency directors/heads appointed by the Secretary of HAFA:

- **Rhode Island Department of Health (RIDOH):** RIDOH will retain most of its current regulatory and public health functions, including licensing and inspecting health care facilities, ensuring safe food and drinking water, and disease prevention and control. However, certain areas of responsibility – such as reviewing and approving/denying hospital conversions, carrying out the Determination of Need (DON), and strengthening compliance with charity care and community benefit standards – will be re-assigned to OHPP. The Health Services Council, historically involved in DON and CEC reviews, will be eliminated.
- **Rhode Island Medicaid Agency (RI Medicaid):** A standalone Medicaid Agency will be codified in statute and established within HAFA to perform Medicaid-focused functions. While HAFA will formally serve as the Single State Medicaid Agency under applicable federal requirements, the Medicaid Agency will perform core delegated tasks. The Medicaid agency will consult closely with OHPP on Medicaid waiver design and will take the lead in implementing and administering waiver programs, in accordance with federal Single State Agency requirements.
- **Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH):** BHDDH will continue to oversee mental health, substance use, developmental disabilities, and certain hospital services. Responsibility for children's mental health services and services for individuals with intellectual and developmental disabilities (I/DD) currently managed by the Department of Children, Youth and Families (DCYF) will be transferred to BHDDH, consistent with the recommendation of the 2022 Special Legislative Commission.[158]

158. Final Report - Legislative Commission to Review and Make Recommendations Regarding the Efficient and Effective Administration of HHS Programs in RI.pdf, at 8.

- **Office of the Health Insurance Commissioner (OHIC):** OHIC will be administratively placed within HAFA instead of the Department of Business Regulation, while retaining its full range of insurance regulatory and affordability functions, including health insurance rate review, affordability standards enforcement, and consumer protection. Certain strategic policy workstreams, such as holding annual cost trends meetings, performing provider payment rate reviews to inform future legislation, and coordinating Medicare § 1115A demonstration program implementation (e.g., the AHEAD model), will be transferred to OHPP. The Commissioner will be appointed by the Secretary of HAFA.
- **HealthSource RI:** HealthSource RI will maintain its status as the State's health insurance exchange, operating pursuant to 45 CFR § 155.110, but will be administratively placed within HAFA. HealthSource RI's functions, funding structure, and governing board composition will remain unchanged, but the Secretary of HAFA will nominate the governing board members and Director, rather than by the Director of Administration.

With respect to the many advisory boards, commissions, committees and task forces created by EOHHS and its component agencies, the new agency heads (OHPP, HAFA, HSA), in consultation during the temporary transition, shall conduct a comprehensive review of all existing advisory committees. Each committee will be individually assessed to determine whether it should be retained, restructured, or eliminated.

**2. Human Services System Regulatory Roles Assigned to the Human Services Agency (HSA)**

The Human Services Agency (HSA) will serve as the executive agency responsible for the administration of all non-health-related human services programs. HSA will act as an umbrella agency to coordinate and share resources among its subagencies to manage collaboration with other executive branch agencies. Like HAFA, HSA will be led by a Secretary appointed by the Governor with advice and consent by the Senate. The HSA will oversee the following components, with directors appointed by the Secretary:

- **Department of Human Services (DHS):** DHS will retain oversight of public assistance programs, including SNAP, Rhode Island Works, childcare subsidies, and other social programs. It will also retain its current ministerial responsibilities associated with making individual Medicaid eligibility determinations.

- **Office of Healthy Aging (OHA):** OHA will retain oversight of programs and policies serving Rhode Island's older adult population, consistent with its current functions.
- **Department of Children, Youth & Families (DCYF):** DCYF will retain responsibility for child welfare and juvenile justice services. However, oversight of children's behavioral health and I/DD services will be transferred to BHDDH within HAFA.
- **Office of Veteran's Services (RIVETS):** RIVETS will continue its mission of supporting Rhode Island's veteran population, consistent with its current statutory functions.

As previously discussed, this Proposal seeks to consolidate the State's core human services programs under a single agency—the Human Services Agency (HSA)—with its Secretary reporting directly to the Governor. This structure will allow HSA to focus on its central mission and strategic priorities. The functions and responsibilities of HSA's subagencies will remain largely unchanged from their current form. What would change is the alignment and governance model, creating clearer accountability, streamlined decision-making, and stronger executive oversight. This approach will allow the State to deepen its talent pool and expertise in human services administration, while maintaining sufficient opportunities for cross-agency collaboration and partnership where missions intersect.

**3. Cross-Agency Interaction and Reorganizational Objectives**

This Proposal reallocates key strategic policymaking to OHPP. To ensure that vision is properly carried across Rhode Island's regulatory ecosystem, the elimination of EOHHS and the reorganization of its constituent agencies provides a necessary reset to help clarify roles and responsibilities and align all regulators with a shared framework for performing their distinct functions.

While located within HAFA for administrative purposes only, OHPP will operate as an independent cabinet-level agency alongside HAFA and HSA. This structure is designed to elevate OHPP's research, analytic, and strategy policymaking responsibilities while preserving its formal independence from the other agencies. OHPP's independence will enhance its ability to generate objective, forward-looking analyses in support of effective governance and

policy development. Nonetheless, OHPP will maintain constant oversight and collaboration of HAFA by providing in-depth data, research, strategic planning, and health system monitoring to inform and support HAFA's operational and regulatory actions.

This reorganization is designed to resolve longstanding challenges within the State's health regulatory framework. The establishment of two separate agencies (HAFA and HSA), each led by cabinet-level Secretaries, will establish clear lines of authority and accountability while cultivating expertise and oversight aligned with the unique functions of each agency. Empowering the Secretaries to appoint leadership within their respective departments will further promote accountability by centralizing reporting structures, ensuring that each Secretary remains directly responsible to the Governor, and ultimately the public, over agency performance.

At the same time, elevating OHPP to a cabinet-level agency – led by independent Board members – will reinforce the importance of health system planning and data-informed policy. OHPP's novel analytic capacity will reduce over-reliance on external consultants, strengthen institutional memory, and enhance the state's ability to respond to emerging health system challenges.

The reorganized structure also elevates the State's Medicaid program by establishing it as a dedicated department within HAFA, consistent with other HAFA departments and with the 2022 recommendations of the Special Legislative Commission. Historically, the Medicaid program has been underfunded and insufficiently prioritized within RI's health care governance. This reorganization will place the Medicaid Agency on par with its sister agencies, ensuring its strategic importance is reflected in state policy and resource allocation. Establishing this parity is intended to foster long-overdue investment in Medicaid payment rates, program integrity, and delivery system innovation.

The broader reorganization proposed herein is designed to make meaningful improvements across several key areas. For example, chronic staffing shortages and retention challenges have impeded the performance of EOHHS and its constituent agencies. Clearly defined and more focused missions will help both OHPP and the new regulatory agencies better recruit and retain talent. This reorganization will provide an opportunity to re-evaluate staffing structures, increase leadership autonomy in recruitment and retention, and prioritize staff

development aligned with policy goals. It also provides an opportunity to examine and address any fiscal or operational gaps that may currently exist.[159]

By separating health system oversight from human services delivery and aligning these domains under dedicated cabinet-level leadership, this proposal will allow Rhode Island to achieve a more accountable, responsive, and sustainable health regulatory infrastructure.

# IV. Implementation Considerations

The creation of OHPP, alongside the reorganization of EOHHS into two new agencies (HAFA and HSA), will require a coordinated, phased implementation process to ensure operational effectiveness entailing interdependent legislative, personnel, and operational workstreams.

## A. Fiscal Implications

The establishment of the Office of Health Policy and Planning (OHPP) and the reorganization of EOHHS represent significant and necessary investments in Rhode Island's health care infrastructure. Both initiatives will require one-time start-up costs, as well as ongoing operational funding. Start-up costs are expected to be limited to non-recurring items, such as transition consulting and IT system reconfiguration. Incremental costs associated with this regulatory restructuring will also be limited to those associated with the increased staffing for OHPP.

While these investments come with upfront costs, they are expected to yield substantial long-term benefits, including clearer lines of accountability, improved regulatory coordination, and the development of in-house expertise that can reduce the overreliance on external consultants. Consolidating regulatory functions may also reduce duplication and administrative overhead over time. Ultimately, the primary objective of this Proposal is to establish a resilient, proactive health regulatory infrastructure and make the upfront investments necessary to avoid more serious financial crises or taxpayer-funded emergency bailouts in the future.

Legislators and policymakers will need to consider the appropriate funding streams for the creation of OHPP and to cover any transition costs arising from agency reorganization. In other states, the establishment of new health care

159. *See, e.g.,* RI Auditor General, Single Audit Report (2024), https://www.oag.ri.gov/reports/SA_RI_2024.pdf

agencies has often entailed identification of dedicated funding streams that ensure the new agency's independence and sustainability. To support OHPP's fiscal independence and sustainability, possible sources of funding may include but are not limited to:

- One-time and/or recurring special assessments on regulated entities (e.g., insurers, health systems); or
- Revenue from health-related taxes (e.g., excise tax on high-sugar beverages, alcohol purchases, etc.)
- Hybrid approaches involving partial funding through annual appropriates and special assessments / taxes.

Annual reporting requirements, as well as one or more interim implementation progress reports, will ensure that the legislature and the public have necessary and timely access to information to gauge fiscal effectiveness and inform future policy directions.

## B. Legislative Framework and Transition Processes

The precise statutory framework necessary to effectuate these changes is being published alongside this white paper for public/stakeholder input over the coming months. This legislative framework establishes the independent OHPP and creates a framework and timeline for transferring existing authorities, functions, and duties housed in EOHHS and other existing regulatory agencies to HAFA, HSA, or OHPP respectively. The legislative framework also clearly delineates leadership roles responsible for oversight of each agency.

Given OHPP's role to serve as the state's central hub for health system data and analysis, and the need to support new governance structures within HAFA and HSA, we recommend creating a comprehensive data and IT modernization strategy that clarifies which IT functions will or will not require changes as result of this recommended reorganization. This IT modernization strategy will guide integration of the All-Payer Claims Database, the Ecosystem platform, RIBridges, and other data linkages. In general, we recommend close collaboration with Department of Administration (DOA) on the transition process to leverage DOA's experience in establishing new state agencies, recruiting and building workforce capacity, and budgets for future activities. In particular, due to the lack of in-house information systems expertise and the difficulty of recruiting skilled professionals to state service, primary responsibility for necessary IT transitions should reside with the DOA's Division of Enterprise Technology Strategy and Services, working in coordination with

OHPP's Center for Data Collection & Analysis. Rhode Island's existing interagency governing boards which manage its shared IT infrastructure should continue and grow in the new structure. In addition, the State should continue to invest in and investigate modular, cloud-based systems that can be more easily shared across agencies and potentially reduce long-term costs as benefit determination and data analytics systems continue to modernize.

Implementation of the structural reforms proposed herein can be organized into three distinct phases.

**Phase 1** focuses on statutory enactment, including establishment of OHPP and creating the framework for reorganization of EOHHS to establish HAFA and HSA. This phase also includes the appointment of the Secretaries of HAFA and HSA, an Executive Director of OHPP, and OHPP board members. As part of Phase 1, we recommend appointing a temporary implementation lead to work collaboratively with OHPP, HAFA, and HSA leadership, providing strategic guidance on early-stage implementation and appointments. In addition, Phase 1 will involve creation of an exhaustive inventory of each agency's current functions and responsibilities to ensure these are fully captured in the transition and overseen by the appropriate regulator.

**Phase 2** involves the formal transition of agency staff into the reconstituted structure. This phase will also include recruitment of new agency staff to perform novel statutory functions. Given the need for significant coordination between agencies to ensure effective transition of regulatory roles, we envision formal memoranda of understanding (MOUs) to be executed to manage transfers of responsibilities, coordinate enforcement and regulatory functions, and clarify data-sharing obligations.

**Phase 3** will entail full programmatic launch, with agencies performing full regulatory and oversight duties.

## C. Stakeholder Input

Successful administrative reform depends not only on structural change but also on sustained public engagement. Early and ongoing input ensures policies align with community needs and experiences, helps refine operational design, and strengthens the legitimacy and effectiveness of these initiatives.

Following the release of this Proposal, RIAG plans to solicit continued stakeholder engagement. We hope to gather feedback from members of the public, providers, insurers, advocates, labor organizations, and public officials, among others. This feedback will be taken into account in future policymaking efforts.

In particular, comments are requested on the following topics:

- Identifying areas of overlap or gaps in current responsibilities that have not been addressed but could affect efficiency or accountability;
- Integrating platforms such as the All-Payer Claims Database, RIBridges, Ecosystem, and others, while minimizing impacts on access; opportunities to modernize existing IT systems or data-sharing processes to support the new functions of the CDCA;
- Existing data-reporting and data collection channels that should be considered;
- Proposed appointment processes for the OHPP Board, and HAFA and HSA subagencies;
- Proposed changes to the review process for DON applications, hospital conversions, CEC applications, and material change transactions;
- Phased implementation and transition plan (Section V.A);
- Preferred sources of funding for OHPP;
- Interactions with AHEAD Model: integration of technical capabilities and responsibilities required for participation in AHEAD into the regulatory structure outlined in this Proposal.

# V. Conclusion

Reflecting on the structural challenges identified throughout this Proposal, it is clear that RI's health care system faces persistent challenges that limit the State's ability to ensure access to high-quality, affordable health care. System oversight remains fragmented across multiple agencies, and state government currently lacks sufficient capacity for data analysis and long-term system planning.

After examining the State's current health care system, identifying structural challenges, and outlining a path form reform, Rhode Island stands at a critical juncture. The key reforms outlined in this Proposal – notably the creation of the Office of Health Policy and Planning and the reorganization of EOHHS – draw on successful models implemented in other states and are designed to strengthen accountability, enhance analytic capacity, and improve responsiveness across the State's health care system.

By modernizing Rhode Island's health and human services structure, the State will be better positioned to anticipate and respond to emerging health system challenges, promote long-term stability, and ensure effective oversight. Rhode Islanders deserve access to affordable, high-quality health care, and the reforms outlined in this Proposal will help ensure that promise is realized for years to come.

## Appendix 1

### Recommendations of the Special Legislative Commission (September 2022)[160]

- **Recommendation 1: "Create a Medicaid Department within EOHHS and elevate the role of Medicaid Director, requiring Advice and Consent by the Senate."** The Commission explained that this would align with the structure used in most other states, minimize cross-pressures the Medicaid program faces due to its placement within EOHHS, and would help to promote accountability over the largest single category of the state's budget.
- **Recommendation 2: "Remove Hospitals from the Department of Behavioral Health, Developmental Disabilities and Hospitals and create a Department of Hospitals."** The Commission observed that, because regulation of hospitals differs from regulation of other facilities, weighing in favor of creating a separate department of hospitals. The Commission also highlighted the importance of recruiting personnel with specialized expertise in hospital administration and financing to administer the new department. The Commission also recommended that EOHHS explore structuring the new department as a "quasi-public agency."
- **Recommendation 3: "Add children's behavioral health (BH) and children's developmental disabilities (DD) to the charge of BHDDH."** The Commission explained transferring these responsibilities from DCYF to BHDDH would promote continuity of care for individuals, particularly during the youth-to-adult services transition process and may lead more individuals to seek access to services due to community perceptions about DCYF involvement.
- **Recommendation 4: "Strengthen accountability by giving the EOHHS Secretary authority to make recommendations to the Governor regarding appointment and removal of the agency directors."** Citing similar structures in Massachusetts, the Commission stated this would provide the Secretary with an important mechanism to form an effective and efficient team.
- **Recommendation 5: "Create a stakeholder group to ensure appropriate input for the rate review process that was included in the 2023 budget [rate review for social and human services providers] to hold the Office of the Health Insurance Commissioner (OHIC) accountable through public meetings, ensuring that the process is transparent."** The Commission stated this stakeholder group's involvement could improve access to services in communities.
- **Recommendation 6: "Create a Health and Human Services Cabinet, which the Secretary would be held accountable for convening, in order to achieve certain outcomes that would be reported to the legislature on a regular basis."** The SLC explained that the purpose of the Cabinet would be to promote cross-agency collaboration, make more effective use of data, and coordinate on creation of policies that enhance health equity and improve population health outcomes.

160. *Id.* at 7-12.

## Appendix 1

### Recommendations of the Special Legislative Commission (September 2022)[161]

- **Recommendation 7: "Increase the salary of the Secretary of EOHHS, and the salaries of the directors of agencies that report to EOHHS, in order to support recruitment and retention."** The SLC noted that, given that EOHHS oversees such a large portion of the state budget and such widely used programs, compensation should be competitive with comparable roles throughout the region.
- **Recommendation 8: "Include the Department of Children, Youth and Families in the biannual Caseload Estimating Conference (CEC)."** The Commission also recommended that EOHHS use CEC to "inform staffing levels within EOHHS, its sub-agencies, and within the community agencies who provide state-contracted health and human services to Rhode Islanders." The Commission noted there was a need for more attorneys within EOHHS and recommended a wage analysis to avoid agencies competing over legal staff.

161. *Id.* at 7-12.

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