RIDOH issues approval with conditions of initial application for sale of Fatima, RWMC

PROVIDENCE – The Rhode Island Department of Health (RIDOH) announced on June 20th its approval with conditions of a Hospital Conversion Act (HCA) application for the sale of Roger Williams Medical Center and Our Lady of Fatima Hospital. The decision contains several stringent conditions intended to ensure the financial viability of the hospitals, stable operational structures at the facilities, and a continued commitment to health equity and the needs of all patients in the hospitals' communities.

The hospitals are currently owned by Prospect Medical Holdings and are operated by CharterCARE Health Partners. These hospitals provide essential services to vulnerable populations in the state and are served by staffs of dedicated and committed healthcare workers. The prospective buyer, the Centurion Foundation, is a Georgia-based non-profit company.

"Rhode Island needs a stable network of hospitals that supports the health and wellness of every community in the state," said Director of Health **JERRY LARKIN, MD**. "In light of the historical and ongoing financial and operational challenges at the hospitals, RIDOH issued a decision today with conditions carefully developed to restore local control, help stabilize these two facilities, and help ensure that the new operators would be positioned to provide consistent, safe, high-quality care."

RIDOH and the Rhode Island Attorney General review HCA applications. Attorney General **PETER F. NERONHA** also issued an approval of the HCA application today, with a separate set of conditions.

Separate, additional approvals of Change in Effective Control (CEC) applications are also required of the transacting parties. All licensed healthcare facilities are subject to CEC reviews for changes that would affect 50% or more of the entity's ownership, assets, membership interest, authority, or control. Only hospital transactions are subject to an additional HCA review. RIDOH alone issues decisions on CEC applications after the Director of Health receives recommendations on those applications from the Health Services Council. (RIDOH has not yet received complete CEC applications for the sale of Roger Williams Medical Center and Our Lady of Fatima Hospital.)

The conditions contained in the decision include:

- Centurion is responsible for ensuring the hospitals remain in good standing with financial obligations.
- Governing bodies for the hospitals must be maintained and include a majority of independent board members and individuals with experience in hospital operations, healthcare, finance, law, business, labor, investments, community purpose, and diversity, and they must represent the diverse populations served by the hospitals.
- The transacting parties must hire a Chief Restructuring Officer to manage business affairs, oversee financial management, and explore strategic alternatives.
- Prospect Medical Holdings must settle certain outstanding balances with vendors and fund necessary repairs to the hospitals.
- The hospitals may not eliminate or significantly reduce healthcare services without approval from RIDOH. ❖

Attorney General imposes significant conditions on proposed hospital ownership change

PROVIDENCE – Attorney General **PETER F. NERONHA** announced on June 20th that the Office of the Attorney General has issued a decision, pursuant to its authority under Rhode Island's Hospital Conversions Act (HCA), to conditionally approve a transaction that would allow a change in ownership of a health care system that includes two local safety net hospitals, Roger Williams Medical Center and Our Lady of Fatima Hospital, from Prospect Medical Holdings to The Centurion Foundation.

The decision follows a robust review process in accordance with the HCA. The Rhode Island Department of Health (RIDOH), the other state regulator empowered to oversee hospital conversions in Rhode Island, separately issued its own decision on the transaction.

The Attorney General's review revealed significant shortcomings and concerns with the proposed transaction. Accordingly, at the core of the Attorney General's decision are strong conditions that respond to those concerns and are necessary to ensure the viability of the system and the continuity of health care services and operations at Roger Williams Medical Center and Our Lady of Fatima Hospital. These conditions require proper funding, management, planning, and community input and benefit, as non-negotiable stipulations for the approval of the sale.

"Our team was guided by the baseline principle that Rhode Islanders deserve quality, accessible and affordable health care," said Attorney General Peter F. Neronha. "We also know that the future of these hospitals is critical to the collective landscape of health care in Rhode Island. This decision and the conditions we have placed on the transfer of ownership were only arrived at after careful consideration and strong scrutiny."

Altogether, the Attorney General's decision imposes 40 unique conditions across seven areas, with the following conditions highlighted as particularly critical to ensure the viability of the system and its hospitals:

- To address the currently precarious status quo and to address the application's failure to present an adequate level of funding for the hospitals to meet their operating and capital needs;
- Prospect must cure all of the life safety and physical plant violations cited by state and federal regulators, including but not limited to, repair of the roof and inadequate life safety equipment;
- Prospect must come into compliance with the 2021 Decision, including ensuring payment of outstanding accounts payable owed to vendors of the Rhode Island Hospitals;
- Prospect and Centurion must commit to guarantee $80 million in cash financing to add to the books of the New CharterCARE System, regardless of any failure to secure that amount through the bond transaction;
- Prospect and Centurion must contribute an *additional* $66.8 million to a dedicated fund, toward which Prospect may apply the outstanding escrow funds (~$47 million) from the 2021 Decision, to support the newly non-profit New CharterCARE System – funds which will not be available for Centurion's management fee or for executive compensation; and
- Centurion's management fee will be paid only to the extent that the Transacting Parties remain in compliance with all conditions of the Decision;
- To mitigate poor management practices in the past by distant and self-interested owners, the board of the New CharterCARE System must adopt specific best governance practices, include local and community input, and may not alienate, encumber, or pledge New CharterCARE System's assets without notice to and approval by the Attorney General;
- To address the application's lack of a credible plan to turn CharterCARE System's long history of operating losses into New CharterCARE System's ongoing state of sustainable operations, Prospect and Centurion must fund a turnaround consultant to be approved by the Attorney General;
- To address the application's reliance on future, contingent events like IRS approval of non-profit status for any chance of success, conditions specifically mandating the timing, level of effort, and manner in which these steps must be completed;
- To ensure that the community's needs are adequately served, New CharterCARE System must adhere to industry standards for charity care and adequately fund identified community health needs; and
- To ensure continuity of quality care, the New CharterCARE System must notify the Attorney General of any reductions in workforce that meet a certain threshold, and must maintain the current level of employee benefits during the initial period following the closing of the Proposed Transaction. ❖

With new investments and affiliation agreements, Lifespan to become Brown University Health

PROVIDENCE, RI [LIFESPAN AND BROWN UNIVERSITY] – Amid ongoing headwinds facing the health care sector, Lifespan health system and Brown University have finalized terms on a set of expanded affiliation agreements. As part of the agreements, Lifespan will change its name to Brown University Health later this year.

Lifespan President and CEO **John Fernandez**

Brown President **Christina H. Paxson**

The agreements also include reciprocal financial investments between Lifespan and Brown, which will continue as separate, independent organizations after the implementation of the Lifespan rebrand to Brown University Health. A $15 million to $25 million annual investment from Brown to Lifespan, totaling $150 million over seven years, will be devoted to strengthening Lifespan's financial capacity to sustain and advance the shared academic mission of the two organizations. Following that period, Lifespan will invest $15 million annually to support the Warren Alpert Medical School's education and research efforts.

Lifespan President and Chief Executive Officer **JOHN FERNANDEZ** and Brown President **CHRISTINA H. PAXSON** shared details on the new agreements in a Thursday, June 20, event at Hasbro Children's Hospital. Fernandez said these continue to be difficult times in health care, and it is more important than ever that Lifespan solidify and strengthen ties between patient care delivery and Brown as its academic partner.

"We are excited to move forward with robust plans to expand our facilities and improve our systems and technology to be able to compete with new entrants to the health delivery market, such as national chains," Fernandez said. "This enhanced relationship with Brown is one part of the solution to ensure that our health system can continue to offer the people of Rhode Island the opportunity to access high-quality treatment close to home."

Paxson said the agreements advance Brown's goals to ensure that medical students, residents and fellows are learning from outstanding clinicians with opportunities to train using the latest technology and techniques. Brown's investments promise to accelerate improvements including the expansion of electronic health records, and the recruitment of talented academic and clinical leaders as care providers and department chairs for Brown's Warren Alpert Medical School and its affiliated hospitals.

The agreements follow votes by the Lifespan Board of Directors and the Corporation of Brown University, each of which approved a non-binding term sheet directing their leadership teams to negotiate an extension and expansion of the affiliation agreements between the organizations. Lifespan and Brown have long-standing affiliations, which designate Rhode Island Hospital as the principal teaching hospital for Brown's Warren Alpert Medical School, the only medical school in the state. The affiliation dates back to 1969, before a four-year medical program was established at the University.

Investments in Academic Medicine

Fernandez said that in the face of a rapidly and ever-changing health care environment, the new agreements offer a timely and critical step to strengthen a Rhode Island-based health care delivery system and biomedical research structure. He asserted that the industry will likely confront significant headwinds for the foreseeable future, including inflation, labor shortages and low reimbursement rates. For Lifespan, lack of adequate funding over many years has hampered the ability to keep pace with necessary infrastructure investments, he said.

The agreements outline financial investments to address those challenges and establish deeper Brown-Lifespan collaborations in clinical care, medical education, population health, public health and biomedical research.

"It is critical that facilities, systems and technologies are not only modernized, but are cutting-edge in order to be able to compete with out-of-state companies, new entrants to the market and large national providers, particularly for-profit businesses," Fernandez said. "Equally important is investing in workforce development to retain existing, first-rate clinicians and employees and to recruit future top talent. This enhanced relationship is one step in a broader effort to ensure that Rhode Island can continue to offer access to the highest quality medical treatments in a local setting while at the same time generating high paying job opportunities for years to come."

The new agreements impact four broad areas:

(1) New Name

The health system will continue to use the name Lifespan in all of its business operations until its new name officially launches on a to-be-determined date, expected later this year, with the full rebrand taking several years to complete. The official rebranding of Lifespan to Brown University Health – to be referred to commonly as Brown Health – will help the health system recruit and retain physicians, grow research as a recognized academic medical center, and sustain a vibrant medical education program. This will reflect the ability to provide medical care of international caliber to Rhode Islanders, according to health system and University leaders.

(2) New Financial Investments

Beginning July 1, 2024, Brown will make annual contributions of $15 million to $25 million – totaling $150 million over seven years – to support the mission of Lifespan. Following that period, Lifespan will invest $15 million annually for Brown's medical school to support research and medical education, for the life of the agreement.

In addition, the Brown Investment Office will manage approximately $600 million to $800 million of Lifespan's investment portfolio, creating the capacity for increased returns to support Lifespan's mission. The portfolio will be phased in on a schedule expected to be about $200 million per year over four years.

Examples of mission-oriented Lifespan activities and strategic initiatives the funds will be used for include:

- Recruiting physicians to improve access to care for more Rhode Islanders and to attract more patients to come to Rhode Island for care. Increasing out-of-state patient services revenue will help Lifespan offset local costs, while also increasing the number of well-paying health care jobs for Rhode Islanders.
- Investing in state-of-the-art facilities for training world-class physicians and conducting innovative biomedical research in support of a revitalized, resilient and reliable health care system in Rhode Island.
- Continued investment in programs that improve the health, welfare and economy of underserved communities locally. The Lifespan Community Health Institute offers hundreds of programs, events and community service activities serving tens of thousands of southern New Englanders annually. This investment will help Lifespan continue its work to eliminate health disparities and promote health equity through healthy behaviors, healthy relationships and healthy environments.
- Expanding the reach of the Lifespan electronic health record (EPIC). This will allow patients, physicians and medical students to view records for primary care, hospital, specialty, laboratory and imaging services in one portal, enabling more coordinated care by providers, and enhancing the accessibility of health data approved for use in research to improve patient care.

(3) Enhanced Academics and (4) Governance

The agreements establish that the Warren Alpert Medical School dean will serve as Lifespan's chief academic officer. In addition, the president of Brown and the dean of its medical school will become ex officio members of Lifespan's Board of Directors.

The agreements also formalize a series of terms around academic affiliations:

- Rhode Island Hospital will continue to be formally designated as the principal teaching hospital of the Warren Alpert Medical School, recognizing the scope and critical mass of teaching and research activities centered exclusively at Rhode Island Hospital. The other Lifespan teaching hospitals (The Miriam Hospital and Bradley Hospital) will continue to be designated as major teaching affiliates. In addition, Newport Hospital will serve as a community affiliate.
- The Warren Alpert Medical School will be the exclusive medical school affiliate of Lifespan, and Lifespan will continue to be the home of 11 of the medical school's clinical departments. Family medicine, OBGYN and psychiatry academic and clinical chairs will continue to reside at Care New England's Kent, Women & Infants and Butler hospitals. Brown will also maintain its strong academic affiliation agreements with Care New England, the Providence VA Health System, HopeHealth and Brown Physicians, Inc. for teaching, faculty development and research.
- Lifespan will continue to be affiliated with other educational institutions (such as the University of Rhode Island, Rhode Island College and Community College of Rhode Island) for clinical education programs not currently offered at Brown.

Aligning Strengths

Lifespan and Brown are not merging, neither organization will purchase any part of the other, and they will remain separate and independent. For these reasons, the enhanced agreements did not require regulatory or legislative approval. Lifespan and Brown leaders noted they engaged the Rhode Island Department of Health and Office of the Attorney General, and said they appreciated the efforts of both agencies in conducting separate reviews. This included fruitful discussions with the Attorney General, who confirmed that no further regulatory review is required at this time. ❖

Bruce A. Scott, MD, inaugurated as 179th AMA president

CHICAGO – **BRUCE A. SCOTT, MD**, an otolaryngologist from Kentucky, was sworn in on June 11th as the 179th president of the American Medical Association (AMA).

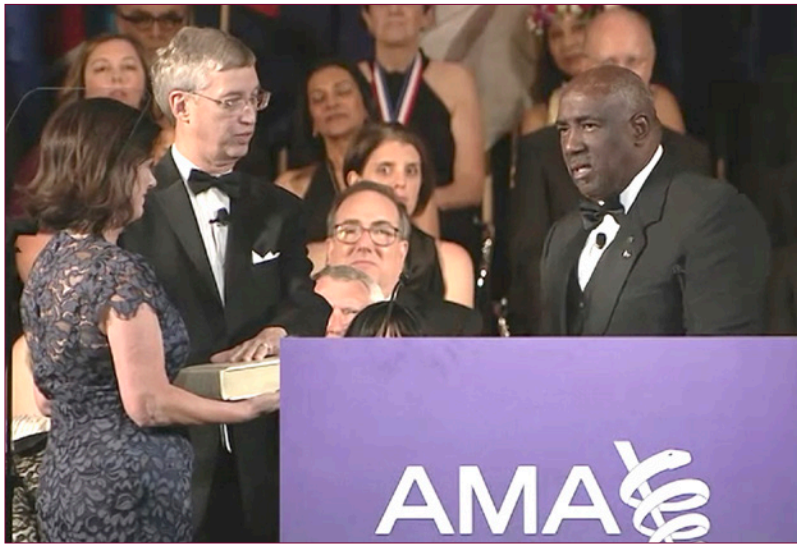
"I became a physician to care for patients, and we all know that's getting tougher every day," Dr. Scott said in his inaugural address. "Our health care system should help physicians provide good care, not get in the way!

"Physicians are struggling with two decades of spiraling Medicare payment cuts and ever-increasing administrative burdens. These concerns are no longer theoretical.

"Almost two-thirds of physicians show signs of burnout. One-third plan to reduce their hours. One in five physicians are hoping to stop practicing or retire in the next two years. Physicians are literally closing their doors. We can't afford to lose even one more doctor! As a physician in an independent practice, I live these issues every day. I see my colleagues struggling. I feel the urgency of the moment. I will bring that urgency to my presidency. You better believe I'm ready to fight."

Dr. Scott has been a leader in medicine throughout his career and a member of the AMA House of Delegates (HOD) for over 25 years. First elected speaker of the AMA HOD in 2019, he previously served as vice speaker and joined the AMA Board of Trustees in 2015.

Based in Louisville and board-certified in both otolaryngology and facial plastic surgery, Dr. Scott is president of Kentuckiana Ear, Nose & Throat, a six-physician independent private practice group, medical director of Premier Ambulatory Surgery Center, and holds a clinical appointment at the University of Louisville School of Medicine.



Bruce A. Scott, MD, at left, with his wife Christy by his side, was sworn in by AMA Board of Trustees Chair Willie Underwood III, MD, as the 179th president of the American Medical Association during its annual meeting held in Chicago in June.

Dr. Scott has been president of his state and county medical associations and continues to serve on the board of the Greater Louisville Medical Society and the Kentucky Medical Association. As a leader of these associations, he has fought for access to care for vulnerable populations, improvement in public health and reduction of administrative burdens in health care.

Dr. Scott earned his undergraduate degree at Vanderbilt University, completed his medical education and residency at the University of Texas Medical Branch (UTMB Health) in Galveston, Texas, and a fellowship at the University of Texas Health Science Center at Houston. ❖

[*Editor's note: The following are excerpts from the inaugural speech by Bruce A. Scott, MD, at his swearing in, which RIMJ attended via Zoom.*]

My Life was Changed by a Doctor

BRUCE A. SCOTT, MD

Good evening and thank you so much for that kind introduction, Dr. Underwood.

Thank you to my esteemed colleagues seated behind me – the exceptional men and women who have held the office of AMA president with honor and distinction – physician leaders from every state, my personal guests who have joined me on stage, each of you has played an indispensable role in my life. And to all of you, it is a privilege to speak to you tonight.

As you heard, I have attended 72 consecutive House of Delegates meetings, that's 36 inaugurations – I have to say, "This one is my favorite!"

I've witnessed amazing physician leaders, over the years, stand at this podium and take that oath. What a rare and precious honor it is for me to stand among the remarkable leaders who've preceded me, many of whom are on this stage with me tonight.

…One of those who is not on this stage tonight is Donald Palmisano. You might have noticed a chair left empty for him in the row of former presidents. Donald was my mentor when I was the young physician on the Board – he probably wondered what he did to deserve that punishment. We actually became close friends.

He called me the "Young Grasshopper," taken from the movie, Karate Kid. I know he is here with me tonight in spirit, as he always promised he would be at my inauguration. Donald always believed, frankly even more than me that someday I would take that oath.

He learned from his father, a beat cop in New Orleans, the advice that he shared with me and so many others, "Do your homework, have courage, never give up." I was listening, Donald.

Thank you also to my family and dear friends who have traveled to

be here this evening – it means so much to share this special moment with you. I know that I only stand here tonight because of the love and support from so many people, many gathered here, and others here in spirit. I am humbled, and grateful.

And I AM READY. As I look out at the faces of so many fellow physicians, I am reminded of the enormity of the decision we made when we chose this profession, and our ability to change lives.

I am reminded of the passion we share for this joy called medicine.

I am in awe off the trust our patients place in us to help them to heal them.

And I am eternally grateful for the way my life was changed by a doctor.

My brother John and I enjoyed building and flying model airplanes as kids. One Saturday afternoon when I was about 12 years old, we were working on one of those planes in the garage of our family home. We needed something from up high in the rafters, so I climbed a ladder and was reaching above my head when the ladder slipped, and I fell. I grabbed for something, anything that would stop my fall…and sure enough, what I caught was a large metal hook that held various tools.

It went straight through my hand.

There I was, in pain and in shock, bleeding down my arm. My mom heard my brother's screams and came running. Later she told me she almost fainted when she saw the hook through my hand. My parents got me to the nearest ER, hook-in-hand, with the spark plug wrench and other tools still hanging on it.

After an examination by a general surgeon, the doctor pulled my parents to the other side of the curtain separating the exam bays. You all know the curtain I'm talking about.

The doctor told my parents that I would need surgery and that I was unlikely to EVER regain normal use of my hand, AND I would probably lose at least two fingers.

Let me tell you, those curtains are not as soundproof as we doctors sometimes think. I heard every single word.

My parents were horrified. But they were not deterred. They believed in the power of physicians to heal, and they were determined to find a doctor who could help me. They took me to Jewish Hospital, home to one of the premier hand surgery fellowship programs in the country. One of their lead surgeons, Dr. Joseph Kutz, operated on my hand that same day. He removed the hook, tools and all.

Dr. Kutz saved my hand and spared my fingers, forever changing the course of my life, and, although I didn't know it at the time, putting me on the path that led to tonight – to this stage, to this incredible moment.

I am a surgeon using this very hand because of a doctor.

…Now, let me tell you why I'm here.

I am passionate about practicing medicine. I am proud of our profession.

What physicians do every day has the incredible power to change lives for the better. I'm proof of that. But as a practicing physician, I can only impact one person at a time.

The AMA does for physicians and our patients what we as individual physicians cannot do.

At my first AMA meeting, I saw the power that physicians could have when we come together as a unified body. All these years later, I still believe the AMA can and does make a difference for our patients and our profession.

We are committed to protecting the patient-physician relationship.

Standing up for science and the ethical practice of medicine.

Pushing back against reckless scope expansions.

Fighting for fair payment that supports thriving practices.

Pressing for relief from administrative burdens so that physicians can focus our attention on what matters most, our patients.

The AMA is the physicians' powerful ally in Congress, in state capitals, in the court room, the board room and the exam room. And the policy issues we discuss and debate here are my working reality. More than at any time I can remember, the AMA matters.

But when the battles are difficult, and victory feels out of reach, it's important to remember our WHY.

It's important to remember what brought us here, WHY we fight.

…I have been blessed to receive many kind notes from patients and words of appreciation over the years. And as much as my patients say that I have helped them, it is their words, and their gratitude, that are my greatest rewards.

This is why we fight. They are why we fight.

When I remember the look on the face of the man, and his spouse, when I told them that the tumor was benign and we were able to save his facial nerve, anticipating a full recovery…

I am reminded of our power to heal.

When I recall the smile of the teenage boy who looked in the mirror as I removed the splint from his previously twisted nose and he was able to breathe through it for the first time in years…

I am reminded of our power to restore.

When a woman told me that the repair of her facial fractures and scars gave her the confidence to leave an abusive relationship, restoring not only her beauty but more importantly her dignity …

I am reminded of our power to change lives.

But most remarkable was the woman for whom I had little to offer who said, "Thank you for listening. Bless you and all the doctors for what you do."

I am reminded, in each of these moments, of our power for caring and compassion.

Years after my hand surgery, I returned to Jewish Hospital, not as a patient, but as an otolaryngologist. One day, I saw my surgeon, Dr. Kutz, in the physicians' lounge. I showed him my hand and I thanked him. He said he remembered the young boy with the hook and all the tools still attached. After thousands of hand surgeries, I suspect he was just being nice, but it didn't matter. He was my doctor. He changed my life. In so many ways he made this night possible.

Each of us is shaped by experiences in our past. But on this night, inauguration night, we look forward to the possibilities of tomorrow. Our future is not the one we wish for but the one we FIGHT for together.

We are not defined by what divides us but what unites us.

We are bound together by our profession, and we must stand together as physicians.

I am honored to be your president and to lead us into that future.

Now, let's get to work! ❖

Bobby Mukkamala, MD, chosen as AMA President-Elect

CHICAGO – Physicians and medical students at the American Medical Association's (AMA) Annual Meeting elected **BOBBY MUKKAMALA, MD**, an otolaryngologist from Flint, Mich., as the new president-elect of the nation's largest physician organization.

Dr. Mukkamala, who has been active in the AMA since residency, is chair of the AMA Substance Use and Pain Care Task Force, serving as a strong voice in advocating for evidence-based policies to end the nation's overdose epidemic. He also played a central role in response to the Flint water crisis, serving as chair of the Community Foundation of Greater Flint with a focus on funding projects to mitigate the effects of lead in children.

Dr. Mukkamala is a past recipient of the AMA Foundation's "Excellence in Medicine" Leadership Award. He was elected to the AMA Council on Science and Public Health in 2009 and served as its chair from 2016 to 2017, before being elected to the AMA Board of Trustees in 2017 and 2021. He has served as a member of the Michigan State Medical Society Board of Directors since 2011, as board chair for two years, and as its president. He is also a past president of the Genesee County Medical Society (GCMS) and continues to serve on the GCMS Board of Directors.

The son of two immigrant physicians, Dr. Mukkamala was inspired to go into medicine and return to his hometown of Flint to serve the community that welcomed his family decades before.

Dr. Mukkamala graduated from the University of Michigan Medical School and completed his residency at Loyola University Medical Center in Chicago. ❖

AMA applauds Supreme Court ruling preserving access to mifepristone

The following statement is attributable to
Bobby Mukkamala, MD
President-Elect, American Medical Association

"The American Medical Association applauds today's [June 13] unanimous ruling by the U.S. Supreme Court that preserves access to mifepristone for millions of women across the country.

"Efforts to second guess the FDA's scientific judgment and roll back access to mifepristone were based on a sham case that not only lacked standing, but relied on speculative allegations and ideological assertions to undermine decades of rigorous scientific review proving the drug is highly safe and effective for both termination of pregnancy and for medical management of miscarriage.

"Substantial evidence shows that restricting access to needed abortion care without justification carries a psychological, physical, and economic toll. Current data show an association between restricted access to safe and legal abortion and higher rates of maternal morbidity and mortality, with already vulnerable populations experiencing the greatest burden.

"The AMA will continue to support access to safe and effective reproductive health care against the ongoing threats of interference in the practice of medicine." ❖

After falling short last Congress, prior auth bill primed for passage

CHICAGO – With the American Medical Association's (AMA) strong support, members of the House and Senate introduced bipartisan legislation today to streamline and standardize the use of prior authorization within Medicare Advantage, building on its widespread support in the last Congress.

An updated version of the **Improving Seniors' Timely Access to Care Act** features targeted policy changes to reduce the scored cost of the legislation, which was an obstacle last Congress.

"We thank the sponsors for writing the bill so it will attract even more support. We came close last Congress to passing this much-needed reform. Our patients know all too well that prior authorization needs a dramatic overhaul. We think this is the year to get this bill over the finish line," said AMA President **BRUCE A. SCOTT, MD**.

In the 117th Congress, the bill garnered 378 total bipartisan cosponsors in the House and Senate and also passed the full House of Representatives. In addition, the legislation secured endorsements from more than 500 outside organizations, including the AMA and numerous national and state medical associations. Again, this year, the bill has similar widespread support.

Members of Congress have been spurred by stories from Medicare Advantage patients who have faced unnecessary delays in treatment and diagnoses because of the administrative hurdles erected by prior authorization.

"This legislation will streamline the prior authorization process so physicians can offer patients safe, timely and affordable care. Those decisions should be made between patients and their doctors without being second-guessed by insurers. The bipartisan and bicameral support for the bill is evidence that this is a common-sense proposal that deserves to be passed," Dr. Scott said. ❖

AMA adopts new prior authorization reform policies during annual meeting

CHICAGO – Physician and medical student leaders at the annual meeting of the American Medical Association (AMA) House of Delegates approved policies aimed at fighting for greater insurer accountability and transparency against the backdrop of proliferating, onerous prior authorization requirements that are delaying and denying necessary care for patients and adding administrative burdens for physicians.

The policies adopted by the House of Delegates address the need for greater oversight of health insurers' use of prior authorization controls on patient access to care. The new policies include:

Insurer accountability when prior authorization harms patients

Health plans continue to inappropriately impose bureaucratic prior authorization policies that conflict with evidence-based clinical practices, jeopardize quality care, and harm patients. In response, the AMA will advocate for increased legal accountability of health insurers when prior authorization harms patients.

"Waiting on a health plan to authorize necessary medical treatment is too often a hazard to patient health," said AMA Board Member **MARILYN HEINE, MD**. "To protect patient-centered care, the AMA will work to support legal consequences for insurers that harm patients by imposing obstacles and burdens that interfere with medically necessary care."

Surveys of physicians have consistently found that excessive authorization controls required by health insurers persistently lead to serious harm when necessary medical care is delayed, denied, or disrupted. Investigations by the inspector general's office of the Health and Human Services Department and Kaiser Family Foundation into prior authorization by Medicare Advantage plans strongly suggest that insurers are denying medically necessary health care.

The AMA will also work to ensure that increased legal accountability of insurers is not precluded by clauses in beneficiary contracts that may require pre-dispute arbitration for prior authorization determinations or place limitations on class action.

Transparency for prior authorization denials

When access to care is denied by a health insurer, patients and physicians should be able to understand the justification for the coverage decision. However, prior authorization programs imposed by health insurers include extensive denial processes that are notoriously opaque, complex, and inconsistent. In response to the need for improved transparency, the AMA will continue working to ensure health insurers provide prior authorization notifications with detailed explanations regarding the rationale for denying access to care.

"Health insurer denials must not be a mystery to patients and physicians," said Dr. Heine. "Without clear information from an insurer on how a denial was determined, patients and physicians are often left to the frustrating guess work of finding a treatment covered by a health plan, resulting in delayed and disrupted care. Transparency in coverage policies needs to be a core value, an essential principle to help patients and physicians make informed choices in a more efficient health care system."

New AMA policy outlines basic information requirements for prior authorization denial letters that include a detailed explanation of denial reasoning, access to policies or rules cited as part of the denial, information needed to approve the treatment, and a list of covered alternative treatments.

While additional information in denial letters is needed, the AMA will also continue its work to support real-time prescription benefit tools (RTBTs) that allow physicians access to patient drug coverage information at the point of care in their electronic health records. RTBTs can streamline access to care and avoid unexpected delays and denials by confirming insurer-approved care or providing therapeutically-equivalent alternative treatments that do not require the insurer's prior authorization. ❖

AMA adopts policies to expand health care coverage

CHICAGO – Physician and medical student leaders at the annual meeting of the American Medical Association (AMA) House of Delegates approved policies aimed at expanding health care coverage for Medicare and Medicaid patients. The new policies adopted include:

Making Medigap policies affordable for Medicare patients

The House of Delegates adopted a resolution calling for a change in federal policy that would reduce costs and burdens to patients who want to switch from Medicare Advantage to traditional Medicare.

If individuals enrolled in a Medicare Advantage plan want to switch to traditional Medicare, they may not be able to enroll in a Medigap plan to handle out-of-pocket expenses. Medigap currently offers a one-time, six-month enrollment period, during which individuals are protected by "guaranteed issue" and community rating, which prevent discrimination based on health, age, or gender. Guaranteed issue protections prohibit insurers from denying a Medigap policy to eligible applicants, including individuals with pre-existing conditions. The new policy supports Medigaps plans offering annual open enrollment periods, guaranteed lifetime enrollment eligibility, and extended modified community rating regulations.

"This guarantee is baked into the Affordable Care Act marketplaces but is not yet part of Medicare. There are good reasons that patients switch to traditional Medicare, and they shouldn't have to pay a higher cost to do so," said **SCOTT FERGUSON, MD**, a member of the AMA Board of Trustees.

Medigap regulations for individuals who are switching Medicare coverage vary from state to state. In some states, patients might see their Medigap policy increase in cost or narrow in coverage – or even become unavailable – once they switch coverage. Other states have enacted Medigap protections for cost, community rating and eligibility.

Under current law, Medigap plans are required to be offered to all Medicare patients over 65 but not to other Medicare patients under 65 on dialysis or with disabilities. The AMA will support efforts to expand access to Medigap policies to all individuals who qualify for Medicare benefit.

Expanding Medicaid coverage to include hearing and vision

With Medicaid's patchwork coverage leaving many patients without access to hearing and vision services, the AMA will work with interested state medical associations to support efforts to cover these vital services and improve health for all Medicaid patients.

Although Medicaid provides basic hearing, vision, and dental services to children, these services are optional benefits for adults enrolled in Medicaid. Coverage varies drastically between states. Twenty-eight states provide limited Medicaid hearing coverage for adults, but many patients are unable to afford hearing aids or access associated care. New AMA policy advocates working with state medical associations to support coverage of hearing exams, hearing aids, cochlear implants, and aural rehabilitative services.

Thirty-three states offer some Medicaid vision coverage, of which 28 states limit access based on severity of vision impairment, pre-existing conditions, restrictions to only eyeglasses, and the number and frequency of visits allowed. New AMA policy advocates working with state medical associations to support coverage of routine comprehensive vision exams and visual aids, including eyeglasses and contact lenses.

Medicaid is not required to provide any adult coverage for dental service; only 19 states offer comprehensive coverage while 31 offered limited or emergency coverage. Medicaid patients routinely forego dental services because of out-of-pocket costs. About 18% of Medicaid patients under 65 report an unmet dental need due to cost, double the rate of privately insured patients. It is estimated that there are 2 million dental-related emergency room visits a year, costing $2 billion. Revised AMA policy supports working with the American Dental Association and other national organizations to improve access to dental care for Medicare, Medicaid, and CHIP patients.

"There's not much logic for why most Medicaid patients don't get comprehensive coverage above the neck. Failure to address vision, hearing and dental issues leads to more severe health problems and represents preventable obstacles to work and everyday life. These services are life-changing and life-saving," said **PRATISTHA KOIRALA, MD, PhD**, a member of the AMA Board of Trustees. "Advocating for a healthier nation means advocating for expanded Medicaid." ❖

AMA House of Delegates adopts policy on medical education

CHICAGO – Physicians and medical students at the Annual Meeting of the American Medical Association (AMA) House of Delegates adopted policies intended to reduce financial burdens for medical school graduates and expand on AMA's work to support the mental health and wellness of medical trainees. The policies adopted include:

Public Service Loan Forgiveness Program

AMA delegates adopted policy calling for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive loan forgiveness when they practice in an Indian Health Service (IHS), Tribal, or Urban Indian Health Program, similar to physicians practicing in a Veterans Administration facility. The policy aims to address urgent physician shortages in the IHS and other programs to increase access to care for patients in rural or underserved areas. The AMA has long advocated for avenues to help new medical school graduates, most of whom graduate with about $200,000 in medical student-loan debt.

"This is a win-win for medical students and tribal communities," said AMA Immediate Past President **JESSE M. EHRENFELD, MD, MPH**. "About 83 million Americans live in areas that don't have sufficient access to a primary care physician. That is unacceptable. At the same time, students are graduating from medical school with huge financial burdens. Working under the IHS or other similar programs offers a great learning experience for new physicians as they serve communities that so desperately need better access to medical care."

Transforming the USMLE Step 3 Exam

AMA delegates adopted policy which supports changing the United States Medical Licensing Examination (USMLE) Step 3 and Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Level 3 from a numerically scored examination to a pass/fail examination and changing the current two-day examination to a one-day exam. The policy also calls for residents taking the exam to be allowed time off to take the exam without having to use their paid time off (PTO) or vacation time. Physicians in training already work long hours caring for patients while also being required to take numerous examinations, such as USMLE Step 3 and COMLEX-USA Level 3, to demonstrate their knowledge. This action seeks to reduce the stress and burnout of meeting these multiple demands.

"Preparing for and taking these exams is time-consuming, costly, and stressful," said **ALIYA SIDDIQUI, MS**, a member of the AMA Board of Trustees. "As medical graduates and residents are embarking on their careers and juggling heavy workloads, they are being forced to use valuable time off to take these exams. Making changes to the testing process will only increase the time that new physicians are able to spend learning in clinical settings with patients." ❖

Commission created to explore potential establishment of medical school at URI

STATE HOUSE, PROVIDENCE – The Rhode Island Senate passed a resolution creating a 21-member commission to study and analyze the state's health care workforce as it pertains to educating and retaining primary care physicians, including the potential of establishing a medical school at the University of Rhode Island.

"Rhode Island is headed for a crisis in primary care," said Senator **V. SUSAN SOSNOWSKI** (D – Dist. 37, South Kingstown), who sponsored the resolution, 2024-S 3165. "While we took important steps this year to address this problem as part of the Senate's health care package, including monetary support for primary care training sites and tuition assistance included in the budget, more remains to be done. While we will continue to work on the aspects of the health package that address the coming primary care crisis, such as reimbursement rates, we also know that these bills are not a silver bullet. We need to explore every avenue we can to ensure Rhode Islanders can access the care they need."

The resolution notes that Rhode Island is experiencing a net loss of primary care clinicians and the shortage is expected to worsen in the years ahead. The inability of many Rhode Island residents to find primary care physicians is resulting in the use of community health centers and urgent care facilities to meet their medical needs, which strains resources and creates additional pressures on the health care system.

While Rhode Island is home to a private medical school, no new medical schools have been established in the state since 1972.

"Rhode Island struggles to retain primary care physicians upon graduationand offset these losses with physicians moving into the state," the resolution states. "Rhode Island must look towards the creation of a college of medicine to train and retain the next generation of the primary care physicians."

The commission is charged with developing and issuing its recommendations to the Senate by December 20, 2025. ❖

Rhode Island selected for Certified Community Behavioral Health Clinic (CCBHC) demonstration grant

PROVIDENCE – Governor **DAN McKEE**, the Rhode Island Executive Office of Health & Human Services (EOHHS), Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), and Department of Children, Youth and Families (DCYF) today announced that Rhode Island is one of 10 states chosen for a federal demonstration program that will help the state in its transition to a new system of behavioral healthcare that provides care for people of all ages, regardless of their ability to pay.

The grant allows Rhode Island to receive Medicaid reimbursements at higher rates for services provided at what are known as Certified Community Behavioral Health Clinics (CCBHCs), helping to reduce the costs borne by the state. The CCBHC model is a national set of standards for comprehensive behavioral health care that is jointly supported by the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Rhode Island was one of 25 states that were eligible for a demonstration grant after winning federal planning grants that helped states work with behavioral health providers to further develop plans for the CCBHC model.

Funding is based on utilization, but the state estimates approximately $15 million in additional federal funding for state fiscal year 2024 and $26 million in additional federal funding for 2025.

Rhode Island's application was prepared by an interagency team from the Executive Office of Health and Human Services/Medicaid, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, and the Department of Children, Youth and Families.

This funding will support the eight CCBHC sites scheduled to open on October 1, 2024, and two new sites.

- **Community Care Alliance**
  serving Burrillville, Cumberland, Lincoln, North Smithfield, and Woonsocket
- **Family Services of Rhode Island**
  serving Providence
- **Gateway Healthcare Pawtucket**
  serving Pawtucket and Central Falls
- **Gateway Healthcare Johnston**
  serving Cranston, Foster, Glocester, Johnston, North Providence, Scituate, and Smithfield
- **Gateway Healthcare South County**
  serving Block Island, Charlestown, Exeter, Hopkinton, Narragansett, North Kingstown, South Kingstown, Richmond, and Westerly
- **Newport Mental Health**
  serving Jamestown, Little Compton, Middletown, Newport, Portsmouth, and Tiverton
- **The Providence Center**
  serving Providence
- **Thrive Behavioral Health**
  serving Coventry, East Greenwich, West Greenwich, Warwick, and West Warwick

The providers cover a catchment area that reaches 91% of Rhode Islanders. The state is working to bring additional CCBHCs online in the following year for 100% coverage. Two additional sites, Amos House and East Bay Community Action Program, are actively pursuing certification to join the CCBHC program beginning October 1, 2025.

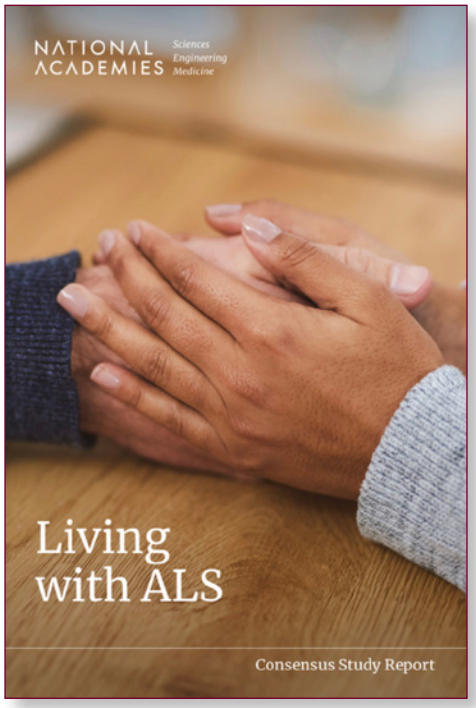
EOHHS will be implementing its CCBHC across most of the State on October 1, 2024. With its partial-year implementation in SFY 2025, EOHHS anticipates that Rhode Island's participation in the CMS Demonstration will provide $15 million in state savings.

When measured on an annual basis and potential expansion for new providers, overall spending on what is a critical component of Rhode Island's behavioral health safety net is anticipated to increase from less than $70 million in SFY 2024 to nearly $240 million in SFY 2026. With $26 million in enhanced federal financing provided by the CMS Demonstration, the unprecedented investment of $170 million into its behavioral health system will cost $40 million in new state spending.

For more information about Certified Community Behavioral Health Clinics in Rhode Island, please visit the EOHHS CCBHC webpage. ❖

Report urges immediate and longer-term actions to improve services for people with ALS, speed development of therapies

WASHINGTON – A new congressionally mandated report from the National Academies of Sciences, Engineering, and Medicine recommends actions Congress, federal agencies, insurers, and others should take to strengthen health care and support services for people with amyotrophic lateral sclerosis (ALS) and accelerate research on therapies for the disease – with the goal of turning ALS into a livable disease within a decade.



Currently there are no treatments that stop or reverse disease progression, though services exist to help manage symptoms. At any given time, at least 30,000 individuals in the United States are estimated to have ALS.

"Receiving a diagnosis of ALS is devastating for the individual, their family, and their caregivers," said **ALAN LESHNER**, chief executive officer emeritus, American Association for the Advancement of Science, and chair of the committee that wrote the report. "Dealing with this illness requires a complex array of medical and support service interventions, and the intensity of care required increases exponentially over time. Implementing the vision laid out in our report would go a long way toward achieving the goal set in the committee's charge of making ALS a livable disease within a decade."

The committee – which included scientific and clinical experts from a variety of fields, as well as people living with ALS or at clear risk for developing it – defined ALS as being "livable" when an individual diagnosed with the disease can survive, thrive, and live a long, meaningful life while meeting the medical, psychosocial, and economic challenges of the disease.

Short-term actions that are feasible immediately

The report recommends concrete immediate actions that would have an important impact on livability for people with ALS and their caregivers. For example, the Centers for Medicare and Medicaid Services (CMS) and private insurers should act quickly to provide coverage for and ensure access to home-based and outpatient physical and other support services for persons with ALS as necessary, and to commit to expedited (within 72 hours) responses to prior authorization requests for all therapies, durable medical equipment, assistive technologies, and services for persons with ALS.

In addition, Congress should provide a tax credit that could be used by unpaid caregivers of individuals living with ALS, the report says. CMS should test approaches for paying stipends directly to caregivers on at least a monthly basis and providing access to high-quality respite services.

Building the ideal ALS care delivery system

Making ALS a livable disease requires diagnosing individuals earlier and initiating evidence-based multidisciplinary care by ALS specialists immediately and continuously, the report says. It urges the development of an integrated, multidisciplinary system that would provide high-quality care and access to research opportunities for all people with ALS, filling gaps in access across the U.S.

The system – modeled after "hub and spoke" systems of care and research for cancer and stroke – would build on what already exists in the ALS clinic system and would comprise three care settings: community-based ALS centers; regional ALS centers; and comprehensive ALS care and research centers. The system should be developed by CMS and the National Institute of Neurological Disorders and Stroke, in partnership with leaders of current ALS multidisciplinary care clinic systems. Reimbursement practices should be realigned to support this multidisciplinary care model.

Advancing ALS research and accelerating development of therapies

The history of drug development for ALS is filled with many failures and too few successes. Over the past decade, research advances have identified a wide range of potential therapeutic pathways and potential drug targets and genes associated with ALS, the report says. However, a lack of biomarkers, overall limited understanding of the disease, and the small pool of available research participants – which is exacerbated by restrictive clinical trial eligibility criteria and delays from symptom onset to diagnosis and clinical trial entry – are factors contributing to the lack of significant success in ALS drug development.

The report recommends the creation of a centralized, dedicated ALS clinical trials network that builds on existing ALS clinical trial consortia. This network would provide a coherent approach to clinical trials and natural history studies that permits faster answers to multiple questions at once. The National Institute of Neurological Disorders and Stroke should ensure the existence of such a network, distributed across diverse geographic regions in the U.S., and coordinated and funded by NIH.

The report also recommends the expansion of translational research and identifies additional research priorities; urges more funding for neglected areas of research that would yield near-term gains in quality of life for people with ALS, such as research on physical therapy and speech and language supports; and proposes the creation of a comprehensive ALS registry capable of collecting detailed longitudinal data on all individuals living with ALS, as well as people at increased genetic risk of developing ALS.

The report notes that while the Department of Veterans Affairs has demonstrated an exemplary system of ALS care that is interdisciplinary, proactive, and patient-centric, veterans receiving ALS care within VA clinics have limited access to participation in clinical trials. Given the known higher prevalence of ALS in veterans, it is critical to include the VA ALS system of care in the new integrated ALS network of care and research proposed in the report.

Preventing ALS

Additional research is also needed on populations at risk of developing ALS, the report says. Research that identifies new targets for therapeutic intervention, biomarkers of ALS, and risk factors and environmental exposures contributing to the development of ALS raises the possibility of developing agents or interventions that can delay or even prevent the development or progression of ALS. Research funders should partner with drug developers and the ALS community to advance research focused on people at risk of developing ALS, including at-risk genetic carriers. In addition, CMS and private insurers should increase access to genetic testing and counseling for people with ALS and their families.

"Making ALS a livable disease within a decade will require commitment, resources, and leadership from many relevant parties, but the impact will be great for the more than 30,000 individuals living with ALS and the thousands more who are at risk of developing this terrible disease," said **VICTOR J. DZAU**, president of the National Academy of Medicine. "Carrying out the report's recommendations would provide greater and more equitable access to state-of-the-art multidisciplinary care, accelerate the development of more effective treatments, improve the quality of life and health of those individuals suffering from ALS both now and in the future, and provide essential support for families and caregivers."

The study – undertaken by the Committee on Amyotrophic Lateral Sclerosis: Accelerating Treatments and Improving Quality of Life – was sponsored by the National Institute of Neurological Diseases and Stroke of the National Institutes of Health. ❖

Reed & Whitehouse announce $5.4M for emergency preparedness

WASHINGTON, DC – In an effort to help ensure that Rhode Island's medical facilities and health care systems are prepared for natural disasters and public health emergencies, U.S. Senators **JACK REED** and **SHELDON WHITEHOUSE** announced that the Rhode Island Department of Health will receive $5,415,557 to continue improving preparedness and health outcomes for a wide range of public health threats.

Rhode Island will receive $5 million through the Public Health Emergency Preparedness (PHEP)cooperative agreement and over $415,557 through the Cities Readiness Initiative, which allows cities to work with surrounding communities and their health departments to create coordinated response plans. The federal grants are administered by the U.S. Department of Health and Human Services' (HHS) U.S. Centers for Disease Control and Prevention (CDC).

The federal PHEP funds are designed to enhance the ability of hospitals and health care systems to prepare for and respond to public health emergencies such as natural and man-made disasters, including hurricanes, wildfires, floods, infectious disease outbreaks, and terrorist attacks. PHEP funds help emergency management, fire departments, law enforcement, hospitals, primary care providers, volunteers, information technology staff, and more work together and plan ahead to ensure the health, well-being, and preparedness of our communities is addressed during a range of emergencies.

"This is a smart investment in bolstering public safety and public health. These federal funds will help ensure the Rhode Island Department of Health and local hospitals have evidence-based guidance and operational plans in place to quickly and effectively respond to a range of emergencies. It will bolster the state's capacity to deal with pandemics or deliver treatment to the public in emergencies," said Senator Reed, a member of the Appropriations subcommittee that oversees federal funding for HHS programs. "Our dedicated health workers and emergency responders are critical when disaster strikes. I am pleased to support Rhode Island's robust preparedness system and ensure health and safety officials are ready and coordinating when we need them most."

"This federal investment will help strengthen Rhode Island's defenses against emerging public health threats," said Senator Whitehouse. "By putting funding directly into communities, we are supporting local emergency preparedness and increasing response capacity to keep Rhode Islanders safe."

The CDC estimates that Rhode Island has over 55 PHEP-funded staff, including epidemiologists, laboratorians, nurses, planners, IT specialists, administrative staff, statisticians, and other positions.

The PHEP cooperative agreement was most recently reauthorized through the bipartisan Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPAI) in 2019. While many existing PAHPA provisions were set to expire in September 2023, Congress has temporarily extended several provisions until December 31, 2024 under the Consolidated Appropriations law (P.L. 118-42). ❖