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To: House Committee on Health and Human Services
From: Care New England Health System
Date: May 28, 2026
Subject: CNE Testimony in Qualified Support of H 8500 — Office of Health and Human Services

Dear Chairwoman Donovan and members of the Committee,

Care New England Health System submits this testimony in qualified support of H 8500. The legislation addresses a genuine and documented gap in the state's regulatory toolkit: the absence of real-time financial visibility into the institutions Rhode Island depends upon for essential healthcare services. The financial surveillance framework the bill establishes is a necessary and appropriate exercise of the state's interest in the stability of its healthcare system.

However, Care New England respectfully submits that in its current form, H 8500 contains structural provisions that would undermine its stated goals, create unintended legal consequences, and — most fundamentally — mischaracterize the causes of financial distress in Rhode Island's healthcare sector. We offer the following testimony in the spirit of strengthening this legislation so that it accomplishes what it sets out to do.

Our testimony addresses three areas: the appropriate scope of financial reporting; the risk of conflicts with existing bond covenant obligations; and the critical need to reframe the bill's underlying premise about the causes of institutional financial distress.

I. Recommended Financial Reporting Metrics

The Current Requirement Is Broader Than Necessary

Section 42-7.5-2(a) requires a comprehensive quarterly financial report including balance sheet detail, revenue breakdowns, expense categories, investment income, bad debt, and charity care — among other items. This level of detail is appropriate for audited annual financial statements, which already exist and are already submitted to state and federal authorities.

For the specific purpose H 8500 is designed to serve — early identification of financial distress before it becomes a crisis — this breadth is unnecessary and the reporting burden it creates is disproportionate to the signal it generates. Most of the required data points are lagging indicators. They describe what happened; they do not predict what is coming.

A Focused Predictive Set

The finance literature on organizational distress, and the experience of bond rating agencies and financial turnaround specialists who work in the hospital sector, is clear about which metrics are the leading indicators of financial stress. Care New England recommends replacing the full H 8500 data set with the following six metrics, all of which are producible from existing accounting systems with minimal additional burden:

Metric	Why It Belongs
Days Cash on Hand	Most immediate liquidity signal; below 30 days is a near-universal distress indicator
Current Ratio (current assets/current liabilities)	Measures short-term obligation coverage; deterioration predicts inability to meet near-term liabilities
Operating Margin	Single most reliable indicator of structural versus cyclical distress; sustained negative margin signals fundamental viability risk
Total Operating Revenue	Provides the denominator for margin calculation and flags volume deterioration before it appears elsewhere
Debt Service Coverage Ratio	Most closely watched by lenders; covenant breach is frequently the triggering event that compresses the timeline to crisis
Payables Beyond 90 Days (%)	Earliest behavioral stress signal; institutions under pressure stretch payables before income statement metrics fully reflect the problem

These six data points, submitted quarterly with CFO attestation, provide EOHHS with the early warning signal the bill is designed to create. They are significantly less burdensome to produce than the full dataset the bill currently requires, and they are more directly predictive of the distress conditions EOHHS needs to identify.

Everything else in the current H 8500 data requirement — gross revenue breakdown, expense categories, investment income, non-patient revenue, bad debt detail — is better suited to annual audited financial statement requirements that already exist. There is no need to replicate that reporting burden quarterly when the goal is early warning, not comprehensive financial oversight.

II. Potential Conflict with Bond Covenant Obligations

An Unintended Legal Consequence

H 8500 creates potential conflicts with existing bond indenture agreements and Securities and Exchange Commission continuing disclosure obligations that the bill's drafters may not have anticipated. These conflicts

are not theoretical — they arise directly from the intersection of the bill's mandatory reporting and public disclosure requirements with the contractual frameworks that govern most hospital debt financing.

We identify four specific conflict points:

- **Public Disclosure.** Section 42-7.5-5 requires the Secretary to make findings from submitted reports publicly available. Bond covenants contain carefully negotiated disclosure provisions — material information is disclosed through defined channels, on defined timelines, to defined audiences. A state agency publishing findings about an institution's financial condition outside those negotiated channels could constitute a covenant violation or conflict with SEC disclosure obligations for entities with publicly traded debt.

- **Material Event Disclosure.** A formal finding of financial risk or imminent financial jeopardy by a state regulatory agency is almost certainly a material event under bond indenture agreements and potentially under SEC Rule 15c2-12 continuing disclosure requirements. H 8500 creates a parallel disclosure pathway the institution does not control — the Secretary makes the finding and publishes it on the Secretary's timeline, not the institution's. An institution managing a developing financial situation with its advisors, preparing appropriate disclosures through proper channels, may find that EOHHS has published a finding of financial risk before the institution has made its own controlled disclosure to bondholders.

- **Forensic Audit Rights.** Bond covenants frequently contain provisions about who has audit rights over the borrower's financial records. A state-compelled forensic audit — particularly one that goes beyond the scope of the normal annual independent audit — may conflict with those provisions or require bondholder consent that the bill does not contemplate.

- **Covenant Ratio Thresholds.** Five of the six metrics Care New England recommends — and several of the metrics in the full H 8500 data set — overlap directly with standard bond covenant ratio requirements. Debt service coverage ratio and days cash on hand are nearly universal covenant metrics. Submitting data showing these metrics are below threshold to a state agency before formally notifying bondholders of a potential covenant breach could create legal exposure for the institution and its officers.

The Practical Consequence

For a financially stressed institution, these conflicts create a genuinely difficult legal situation. Complying with H 8500 may trigger bond covenant consequences. Declining to comply creates regulatory exposure. Bond counsel and regulatory counsel may give conflicting advice, and the bill provides no guidance about which obligation takes precedence.

For financially healthy institutions, the concern is prospective: the knowledge that quarterly data submitted to EOHHS could result in a published finding creates an incentive to manage reported metrics rather than report transparently. That outcome is directly contrary to the bill's intent.

Recommended Fix

The Committee should add a confidentiality framework for submitted data that supersedes the public disclosure requirement in cases where disclosure would conflict with existing bond covenant or SEC continuing disclosure obligations. The bill should also include a coordination protocol that gives institutions the ability to make required bondholder notifications before EOHHS publishes any findings related to their financial condition.

III. Reframing the Cause of Financial Distress

The Organizational Incompetence Assumption

This is the most important concern Care New England raises in this testimony, and it goes to the foundational premise of H 8500.

The bill's architecture — quarterly reporting, assessment, findings of financial risk, corrective action plans, forensic audits at the entity's expense — is structurally premised on a theory of organizational failure. It presupposes that financial distress in a reporting covered entity is primarily a product of something the entity is doing wrong or failing to do right. The corrective action framework makes this assumption explicit: if you are in distress, produce a plan to correct your behavior.

This assumption is wrong in the majority of cases this bill will actually encounter in Rhode Island.

The Environmental Reality

The actual drivers of financial distress in Rhode Island's hospital and healthcare sector are predominantly external — conditions the institutions did not create and cannot correct through better management:

- **Medicaid Underfunding.** Rhode Island's Medicaid reimbursement rates are set systematically below the cost of providing care. Care New England alone loses approximately $45 million annually on Medicaid services — requiring a roughly 17 percent rate increase to reach breakeven. This is not a management failure. It is a state policy choice, made consistently over many years, imposed on institutions that cannot decline to serve Medicaid patients without abandoning their community benefit mission and their operating licenses.

- **Medical Malpractice Environment.** Rhode Island's liability environment imposes costs on providers that are a product of the state's legal and judicial framework, not institutional management decisions. Liability insurance premiums, defensive medicine costs, and the chilling effect on specific service lines — including obstetrics — are environmental conditions that no corrective action plan addresses.

- **Regulatory Burden.** The compliance infrastructure required by OHIC, DOH, EOHHS, CMS, and accrediting bodies represents a significant and growing overhead cost. H 8500 adds to that burden while treating the financial consequences of existing regulatory burden as evidence of distress requiring further regulatory intervention.
- **Input Cost Inflation.** Post-pandemic labor costs, pharmaceutical prices, and capital construction costs have accelerated in ways that affect all providers regardless of management quality. These are macroeconomic conditions, not organizational failures.
- **Commercial Reimbursement Compression.** Insurer market concentration in Rhode Island is among the highest in the nation. Individual institutions cannot negotiate their way out of the resulting commercial reimbursement compression.

The Disingenuousness Problem

> ***The state cannot simultaneously assert that these services are essential enough to warrant comprehensive oversight while disclaiming any obligation to address the state-created conditions driving the distress that oversight will document.***

H 8500 makes two simultaneous claims that cannot both be true.

The first claim, embedded in the bill's entire architecture, is that these healthcare services are so essential to Rhode Island residents that the state must have real-time financial visibility into the institutions providing them, with authority to assess their condition, require corrective action, and escalate to the Governor when necessary.

The second claim, stated explicitly in Section 42-7.5-4, is that the state has no obligation whatsoever to provide financial assistance to those institutions regardless of what the assessment finds.

These two positions are in fundamental tension. If the services are essential enough to warrant this level of oversight — and Care New England believes they are — then they are essential enough to warrant a state obligation to address the conditions, including state-created conditions, that threaten their viability.

The relationship deserves to be named directly: Rhode Island is proposing to monitor and investigate the financial consequences of its own underpayment decisions, then require the institutions absorbing those consequences to produce corrective action plans for a problem the state's own policies created.

The Required Reframe

Care New England urges the Committee to add a findings section to H 8500 that accurately characterizes the causes of financial distress in Rhode Island's healthcare sector. That findings section should:

- Acknowledge that the financial conditions the bill is designed to monitor are in part a product of state Medicaid reimbursement policy, regulatory burden, and other state-created environmental conditions.
- Distinguish between organizational causes of distress — management decisions, capital allocation, operational performance — and environmental causes that originate in state policy or market conditions beyond any institution's control.
- Establish that a corrective action plan is an appropriate instrument for organizational causes and an inappropriate instrument for environmental causes.
- Create a reciprocal state obligation: where the surveillance apparatus identifies financial distress attributable in whole or in part to state reimbursement policy or other state-created conditions, the state should have an affirmative obligation to assess and address those conditions — not merely document the distress they produce.

Conclusion

H 8500 establishes a financial surveillance infrastructure that Rhode Island genuinely needs. The absence of real-time financial visibility into the institutions providing essential care — a gap made evident in prior episodes of institutional distress in this state — represents a legitimate regulatory failure that this bill begins to address.

Care New England supports the bill's core purpose and urges the Committee to strengthen it in three ways: focus the reporting requirement on the six metrics most predictive of financial distress; add protections against unintended conflicts with bond covenant and SEC disclosure obligations; and reframe the bill's foundational premise to accurately reflect the environmental causes of financial distress in Rhode Island's healthcare sector.

A surveillance system built on an accurate diagnosis of the problem — one that acknowledges the state's own role in creating the conditions it is monitoring — will be more effective, more legally sound, and more equitable than one premised on organizational incompetence that the evidence does not support.

We appreciate the Committee's attention to these concerns and welcome the opportunity to discuss them further.

Respectfully Submitted,

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Care New England Health System