The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

Statement of
The Hospital and Healthsystem Association of Pennsylvania

for the

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submitted by

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Thank you, Chairman Yaw and Vice Chairman Pashinski. Good morning distinguished committee members and guests. It is my honor to testify before you.

My name is Kate Slatt. I am the vice president of innovative payment and care delivery at The Hospital and Healthsystem Association of Pennsylvania (HAP). HAP represents approximately 235 member institutions, including the overwhelming majority of rural hospitals across the commonwealth.

Over the past seven years, I have been afforded the opportunity to lead HAP's Council of Rural Hospitals and support its work to address operational, regulatory, and legislative challenges. I also serve on the Board of the Rural Health Redesign Center Authority and am a member of its Joint Finance and Operating Committee.

I am passionate about ensuring that all Pennsylvanians are able to access high-quality health care, especially residents of rural communities, who face unique challenges. Thank you for the opportunity to speak today.

Financial Crisis in the Hospital Community

Hospitals are emerging from the largest paradigm-shifting health crisis in more than a century. In its wake are a confluence of challenges that jeopardize our nation's entire health care system. Some of these challenges are hitting Pennsylvania harder than other states, because of

our aging demographics and other factors. And many of these challenges are especially felt in rural communities, due to factors such as hurdles in addressing social determinants of health, greater difficulties recruiting staff, lower patient volumes, and a greater share of the population insured by Medicare and Medicaid, which pay hospitals below the cost of delivering care.

According to Kaufman Hall, "Staffing shortages, skyrocketing labor costs, continuing supply chain disruptions, inflation, rising interest rates, and volatile markets are pressuring both revenue and expenses (of hospitals)." None of these challenges have easy, near-term solutions.

Staffing shortages for nurses and clinical support professionals are disrupting hospitals, nursing homes, primary care offices, and other health care settings. In order to attract and retain high-quality caregivers, wages are significantly higher than in the past. Overall inflation hit a 40-year high in June. Payments from Medicare and Medicaid—which, as I mentioned have historically paid less that the actual cost of providing care—have not kept pace with higher costs. The result is that traditional operating models are burdened by structural deficits that continue to grow and strain hospital liquidity.

According to the Pennsylvania Health Care Cost Containment Council, in fiscal year 2022, 39 percent of Pennsylvania's general acute care hospitals operated at a loss and another 13 percent posted an operating margin between 0 and 4 percent, which is considered insufficient for long-term sustainability. The foregone dollar value for statewide uncompensated care (which includes charity care and unpaid debt) was $752 million.

Operational and fiscal strains are compounded by the fact that more patients are presenting with more advanced disease, which requires more complex care. This exacerbates the stress on hospital teams. It is a vicious cycle.

Health care providers are working to fundamentally retool operations so that they remain viable for the next generation. However, Pennsylvania's incredibly outdated hospital licensure regulations make it very difficult for rural hospitals to be innovative and add further complexity to their already tenuous position.

Hospitals are working to overcome these challenges and transform care for the future. But they cannot do it alone.

Concerns for Rural Hospital Sustainability

Rural hospitals often care for socio-economically challenged and aging patients who are disproportionately dependent on Medicare and Medicaid. The number of patients treated mirrors the number of people who live in the area, which means that rural hospitals serve lower volumes than their urban and suburban counterparts. Meanwhile, there are additional barriers to care—such as transportation and the availability of key social services that mean rural patients have more to overcome in getting healthy through their health care. This combination makes it exceedingly difficult—if not impossible—to achieve economies of scale for many treatment options even as their fixed operating costs remain high. Specialized medical and other supplies—for example—are not less expensive simply because they are shipped to a rural area.

Rural hospitals also have well-documented challenges recruiting and retaining qualified talent, including but not limited to physicians, nurses, technicians, medical assistants, housekeeping professionals, and dietary staff. Recruiting highly specialized professionals, such as physicians, in certain high-demand specialties is exceptionally difficult in rural communities.

During fiscal year 2022, more than one in four rural Pennsylvania hospitals posted a negative operating margin. An additional 14 percent of rural hospitals had operating margins of less than 4 percent, which limits their ability to maintain critical infrastructure and be sustainable in the long term.

In addition to providing essential care, rural hospitals are often the bedrocks of their communities. In most cases, hospitals are not only a significant source of pride for the patients they serve, they are also primary economic drivers. A hospital is among the top 10 employers in 83 percent of the rural Pennsylvania counties where at least one hospital is located.

Recently, over the course of a year, rural hospitals have:

- Provided more than $47 million in charity care
- Contributed almost $24 million in community health improvement/community benefit
- Produced economic value of $14 billion ($8 billion direct, $6 billion ripple)
- Supported more than 69,500 jobs (39,700 direct, 29,800 ripple) that paid $4.4 billion in salaries ($2.9 billion direct, $1.5 billion ripple)

Workforce Shortages Threaten Care

It is not an overstatement to observe that the American economy and labor markets are evolving through seismic shifts.

While every sector of the economy is facing fundamental challenges, the health care sector was distinctively changed by the COVID-19 pandemic. As many other industries were able to transition their employment and business delivery models to be more flexible and largely digital, health care professionals were strained by 24/7/365 direct care of the highest intensity, even as the supports and structures they'd traditionally relied upon ceased to function. Their work was intense and intimate. Their commitment was unwavering. The trauma they experienced is real.

The National Governor's Association notes the following:

"A large percentage of the current healthcare workforce is nearing retirement age, which poses two unique challenges: hiring for positions left vacant by retiring personnel and filling the vacuum of knowledge and experience from these providers… On top of concerns over the rapidly aging healthcare workforce, the COVID-19 pandemic has placed additional stress on healthcare workers. With 20 percent of the healthcare workforce leaving the field since the start of the pandemic and an additional 20 percent contemplating leaving, concerns over staffing and increased workload create additional stress for healthcare workers. Additionally, nearly half of healthcare workers in a 2020 study reported feelings of burnout."

In addition to these observations, it is important to note that, as our population ages, the need for health care is increasing. Simply maintaining the size and makeup of the health care workforce that existed before the pandemic is not enough. We will have to innovate to meet the needs of the future.

Rural hospitals have always struggled with staffing recruitment and retention. The American Hospital Association recently noted that "recruitment and retention of healthcare professionals is an ongoing challenge and expense for rural hospitals. While almost 20% of the U.S. population lives in rural areas, less than 10% of U.S. physicians practice in these communities." It is of particular concerns that even time-tested solutions to educate, recruit, deploy, and retain health professionals simply do not work anymore.

Hospitals are actively exploring and deploying new strategies to help develop, safeguard, and promote the wellness of, and retain, their workforce and embrace the new care models that will sustain access to health care in the future. Despite their concerted efforts, high vacancy rates threaten rural hospital sustainability. For example, a recent HAP study found that Pennsylvania's rural hospitals are currently struggling to fill 39 percent of registered nurse positions.

HAP strongly supports the creation of a Governor's Office of Health Workforce Innovation and Reform—including a Workforce Reform Advisory Council—to ensure the necessary level of focus and cross-agency collaboration that will be needed to address the commonwealth's health care workforce crisis in both the near and long term. HAP also strongly supports policies and investments that strengthen the education for and training pipeline into health care careers.

We emphasize the need to finish the work necessary to implement the legislatively authorized interstate professional licensure compacts, which will make it easier to recruit health care professionals from other states.

We thank the Governor and General Assembly for appropriating more than $11 million to overhaul the state's professional licensing system and urge system designers to work closely with the regulated community to articulate system goals, validate business processes, conduct extensive user testing, and develop meaningful training and technical assistance.

And we note that there is no act that we could consider "too small" to be meaningful in expediting the ability of well-qualified health professionals to begin treating Pennsylvania patients. For example, Senate Bill 25 allows certified nurse practitioners who have met a three-year, 3,600-hour threshold to practice without a physician collaboration requirement. House Bill 155 eliminates an in-person requirement and allows synchronous video as a viable option for interviewing potential direct care provider candidates. House Bill 590 removes a redundant process by which the State Board of Nursing is required to review and approve applications for people to sit for the Pennsylvania nurse licensure exam.

Finally, if they haven't already, we urge every policymaker in Harrisburg to talk directly with a rural hospital to hear firsthand how a proposal to implement government-mandated nurse staffing ratios would devastate access to care in rural communities, resulting in fewer beds and health care services, longer waits for care, and—in the worst cases—hospital closures. HAP would be happy to facilitate that conversation for you.

Profound Concern for Behavioral Health Workforce and Patients

Pennsylvania's rural hospitals are also on the front line of the ongoing opioid epidemic and a key element of the commonwealth's response strategy. And the pandemic worsened a growing mental health crisis.

Pennsylvania's shortage of behavioral health professionals is profound. Fifty-three of Pennsylvania's 67 counties are designated as full or partial Mental Health Professional Shortage Areas.

Before COVID, substance use disorder treatment and behavioral health providers were stretched thin but could care for most of the people who asked for help. That's not true anymore. Estimates suggest that more than half a million Pennsylvanians in need are currently not receiving any mental health care at all.

Delays in behavioral health care can be devastating for patients and usually, by extension, their families. Without timely, consistent, and appropriate intervention, patients' symptoms often progress until they are experiencing a full-blown crisis. By then, so much damage has been done that it's substantially harder—and substantially more resource intensive—for a person to work their way back to mental, physical, social, and financial health.

Hospital emergency departments (ED) across the state are overwhelmed with patients in behavioral health crisis. While EDs continue to improve and evolve their capacity to effectively support patients in crisis, their function is to stabilize patients' immediate physical and behavioral health needs. They are not the appropriate setting for complex psychiatric care.

There are frequent and increasingly long delays in being able to transition patients from EDs to the appropriate settings to access the additional treatment they need. Placement delays require patients to wait in EDs for extended periods—a situation that is stressful for the person in crisis, the health care professionals who want to provide the best care, and the hospital staff charged with finding and coordinating clinically appropriate treatment. I am not exaggerating when I say that it is increasingly common for patients to wait for *weeks* in the ED or *months* on acute care floors waiting for appropriate mental health treatment options to open up.

This not only impedes progress for patients with mental health concerns, it also negatively affects others who need care. You may have been hearing, for example, that wait times have

been steadily increasing for all patients in EDs. Similarly, patients who need to be admitted for other health issues cannot be treated in acute care beds or by clinical staff who are occupied by or treating patients awaiting transfer to meet their mental health needs.

This is a statewide, and even national, challenge. But it is especially concerning in rural communities where access to behavioral health services is already limited.

Pennsylvania's behavioral health care delivery system—including the county-administered HealthChoices Behavioral health program—was designed to foster collaboration, problem resolution, and access to care. Yet, as verified by the Legislative Budget and Finance Committee Community Mental Services Report (February 2021) and the Joint State Government Commission Behavioral Health Care System Capacity in Pennsylvania and Its Impact of Hospital Emergency Departments and Patient Health Report (July 2020), problems persist for people who need complex care.

Whether it is facilitating the transition from an ED to opioid use disorder treatment, screening for maternal drug use, increasing access to medication assisted treatment, or serving as a local nexus for care coordination—the commonwealth's ability to turn the tide on the opioid crisis requires hospitals to adopt new approaches and practices.

As you may surmise, the overall financial health of rural hospitals, the continuum-wide health care workforce shortage, and the profound lack of behavioral health services in Pennsylvania make it exceedingly difficult for rural hospitals to research, resource, and implement new approaches and practices in this area.

Members of both parties and legislators in both chambers have introduced measures to help shore up the mental health delivery system, workforce, and transitions from hospitals to other treatment settings. House Bill 849 includes investments in developing additional behavioral health professionals and building capacity in behavioral health programs across the state. House Bill 22 and Senate Bill 606 support hospitals as they seek to transfer patients to appropriate care settings in a timely manner. House Bill 24 and Senate Bill 445 designate funding and assistance to help integrate mental health screening and services in primary care settings, to identify and treat behavioral health concerns as early as possible.

Telehealth is Essential

As a once-in-a-lifetime societal disruptor, COVID challenged patients, providers, hospitals, and communities in unprecedented ways. It also created an environment for rapid innovation. One area of positive innovation was the expedited evolution and expansion of effective telehealth services.

Early in the pandemic, telehealth was an essential tool in providing ongoing care while reducing the spread of the virus. It became increasingly evident that telehealth was also a way to eliminate distance as a barrier to specialty care; treat patients who cannot or have difficulty reaching in-person care (due to work obligations or transportation limitations, for example); expedite scheduling; and increase the number of patients who can be treated.

Patients increasingly and overwhelmingly expect their providers to offer telehealth appointments in both physical and behavioral health. A specific hallmark of rural providers is that they pride themselves on ensuring the health of their regions by providing care to members of their communities "where they are." Increasingly, they are online or can be best served—at the greatest convenience, with the best access to cutting-edge care—remotely.

Rural hospitals have been continually innovating to meet the needs of their communities. Further support for innovation is necessary to ensure that rural hospitals remain viable.

Medicare programs have made permanent some of the flexibilities granted during the COVID-related public health emergency—including, for example, allowing for telephonic visits when a patient does not have the means for synchronous video and paying for telehealth treatments at the same rate that would be paid for a similar in-person visit in the fee-for-service delivery system. It is vital for Pennsylvania to also ensure that telemedicine payment is assured from all payors, as set forth in Senate Bill 739. We urge you to support this legislation.

Imperative to the success of telehealth is the expansion and improvement of broadband services in rural communities. The Pennsylvania Broadband Development Authority is charged with, among other things, managing more than a billion dollars in federal aid to coordinate broadband efforts across Pennsylvania. The authority is working to implement a statewide broadband plan and to distribute federal and state dollars for expansion projects in unserved and underserved areas of the commonwealth. Thank you for your support of this work, as well

as the General Assembly's efforts to provide funding support. Please stay actively involved. It is not an overstatement to say that some Pennsylvanians' lives may depend on it.

Pennsylvania Rural Health Model

Five years ago, five hospitals and five payors began working together to pilot a new rural health care payment mechanism and delivery model. The program was initially funded by the Center for Medicare & Medicaid Innovation, which explains it this way:

> "The Pennsylvania Rural Health Model (PARHM) pays participating hospitals a fixed amount upfront, regardless of patient volume, empowering these hospitals to invest in high-quality primary and specialty care that address the specific needs of the communities they serve. Model benefits may include: better coordination and linkage of medical and social needs services, chronic disease management, preventive screenings, and substance use disorder treatment. These fixed payments may also give participating hospitals financial stability, given the steady flow of payments it receives through the model."

In short, the Pennsylvania rural health model allows hospitals to step off the fee-for-service hamster wheel and focus on what their communities actually need. It provides hospitals with stable, predictable funding, which enables them to truly transform the care that they provide.

The model has successfully grown to 18 hospitals and six payors and has exceeded one million covered lives. Participant hospitals are estimated to reach 10 percent of the state's population, and contribute $2.4 billion in economic activity. Participating hospitals include:

1. Armstrong County Memorial Hospital (Kittanning, PA)
2. Barnes-Kasson County Hospital (Susquehanna, PA)
3. Clarion Hospital (Clarion, PA)
4. Endless Mountains Health Systems (Montrose, PA)
5. Fulton County Medical Center (McConnellsburg, PA)
6. Geisinger Jersey Shore Hospital (Jersey Shore, PA)
7. Highlands Hospital and Health Center (Connellsville, PA)
8. Indiana Regional Medical Center (Indiana, PA)
9. UPMC Kane (Kane, PA)
10. Meadville Medical Center (Meadville, PA)

11. Monongahela Valley Hospital (Monongahela, PA)
12. Olean General Hospital, Bradford Regional Medical Center (McKean, PA)
13. Punxsutawney Area Hospital (Punxsutawney, PA)
14. Washington Health System Greene (Waynesburg, PA)
15. Tyrone Hospital (Tyrone, PA)
16. Washington Hospital (Washington, PA)
17. Wayne Memorial Hospital (Honesdale, PA)
18. Chan Soon-Shiong Medical Center at Windber (Windber, PA)

It is clear that status quo payment methodologies fall short of supporting the critical health care needs of rural communities. The pilot demonstrates what state policymakers, hospital leaders, and committed payors can accomplish—through partnership and collaboration—when incentives are aligned and transformation is prioritized. Continued support for this innovative work and others is both timely and imperative.

Thank you for this opportunity to share HAP's perspective as it relates to the sustainability of Pennsylvania's rural hospitals. We appreciate the chance to offer commentary surrounding some of the ways we believe you may be immediately effective. I would be happy to respond to any questions you may have.