Health Care in Rural Pennsylvania: Critical Issues and New Models of Care

Testimony Provided to the

Center for Rural Pennsylvania

Public Hearing - Rural Hospital and Healthcare Sustainability

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Good morning and thank you Chairman Yaw for the invitation to participate in the Center for Rural Pennsylvania's Public Hearing on "Rural Hospital and Healthcare Sustainability."

My name is Lisa Davis, and I am the director of the Pennsylvania Office of Rural Health and an outreach associate professor of health policy and administration at Penn State. I am honored to provide this testimony on rural health issues in Pennsylvania to the Board of Directors of the Center for Rural Pennsylvania, Center staff, and those present at this hearing. Thank you for recognizing the need for a focus on rural health.

The Pennsylvania Office of Rural Health (PORH) is one of 50 state offices of rural health in the nation funded by a program administered by the Federal Office of Rural Health Policy in the U.S. Department of Health and Human Services. The state offices of rural health are federally mandated to serve as a source of coordination, technical assistance, and networking; to develop partnerships to advance rural health; and assist in the recruitment and retention of health care providers in rural areas of the state. PORH was formed in 1991 as a partnership between the federal government, the Commonwealth of Pennsylvania, and The Pennsylvania State University. PORH's initiatives focused on rural health policy, small rural hospitals and clinics, health care delivery systems, quality improvement, population health, rural public health, and agricultural safety and health. We are one of 11 state offices of rural health located at a university.

I will focus my initial remarks on new federal and state models designed to maintain or expand access to high quality health care in rural and underserved areas in the nation and the state. I will conclude with a discussion of services provided by Rural Health Clinics and the challenges of accessing maternity care in rural areas.

New Federal Model of Care

Rural Emergency Hospital Model

At the federal level, one of the most significant new models for small rural hospitals is the Rural Emergency Hospital or REH, established by the Consolidated Appropriations Act, 2021 to

address the growing concern over closures of rural hospitals. This new provider type became effective on January 1, 2023 (Centers for Medicare and Medicaid Services, 2022).

Critical Access Hospitals (CAHs) and other rural hospitals that have 50 or less beds that convert to an REH provide emergency services, observation care, and additional medical and health outpatient services such behavioral health, radiology, laboratory, and outpatient rehabilitation. An REH may also establish a separate, distinct part unit licensed as a Skilled Nursing Facility (SNF) to provide post-REH or post-hospital services and can serve as an originating site for telehealth services. An REH may not exceed an annual average patient length of stay of 24 hours and does not have inpatient beds. The November 2022 final rule established an additional monthly facility payment of $272,866 per month in 2023 (or $3,274,392) which will increase each year by the same percentage as the hospital market basket increase (Rural Health Information Hub, 2022).

The Rural Health Redesign Center, based in Pennsylvania, is contracted by the Health Resources and Services Administration to serve as the national technical assistance center for eligible hospitals to be designated as REHs.

Several states have passed legislation and/or regulation to establish the Rural Emergency Hospital model and have hospitals that have converted to that designation. Pennsylvania has several rural facilities interested in exploring the option. To do so, language referencing the REH model must be inserted in the Health Care Facilities Act of 1979. The Hospital and Healthsystem Association of Pennsylvania, the Pennsylvania Office of Rural Health, and the Rural Health Redesign Center are collaborating to finalize proposed language and identify sponsors in the General Assembly. Once the Act has been revised, the Pennsylvania Department of Health will determine how the REH model supports their policy agenda and if approved, the policies, guidelines, and survey requirements will be developed, and the model launched in the state.

Pennsylvania Innovative Hospital Models

The Pennsylvania Department of Health (Department) has launched several hospital models to support an effective and efficient health care system which are described below (Pennsylvania Department of Health, n.d.).

Pennsylvania Rural Health Model

In 2017, the Center for Medicare and Medicaid Innovation (CMMI) provided funds to Pennsylvania to launch the Pennsylvania Rural Health Model (PARHM), to create sustainable access to health care in rural communities (Pennsylvania Office of Rural Health, 2021). Act 108 of 2019 established the Pennsylvania Rural Health Redesign Center Authority (RHRCA), which independently administers the PARHM and the Pennsylvania Rural Health Redesign Center Fund (Pennsylvania Department of Health, 2021). Pennsylvania is the first state to create such a model, centered entirely on rural providers, and more than a dozen other states have contacted these organizations to learn more about the Model (Pennsylvania Department of Health, 2023). To date, 18 small rural hospitals and five insurers, including Medicare and Medicaid, are participating in the Model in Pennsylvania.

Micro-hospital

A micro-hospital refers to an acute care hospital that offers emergency services and maintains facilities for at least 10 inpatient beds with a narrow scope of inpatient acute care services, such as non-surgical services. Formerly known as the "innovative hospital model," this model has proven to be a viable alternative to many facilities and will continue to be an option for providers seeking to offer acute care services in a smaller footprint. There are a number of micro-hospitals both being built or in the process of being established in Pennsylvania.

Tele-emergency Department or "Tele-ED"

Tele-ED refers to the operation of a tele-ED that is staffed by Advanced Practice Providers (APP) 24 hours per day, 7 days per week with a physician available at all times through telecommunications but not physically present in the emergency department. The Pennsylvania Department of Health is making available a structured exception request for eligible low-volume

rural hospitals to operate a tele-ED. To date, one rural hospital, UPMC Kane, has been approved to operate a Tele-ED.

Outpatient Emergency Department or "OED"

An OED refers to an outpatient location of a hospital that offers only emergency services without inpatient beds on-site and is not located on the grounds of a main licensed hospital. Hospitals will be able to operate an OED in rural areas in accordance with the guidance. To date, one rural hospital converted to an OED, UPMC Lock Haven, on April 1, 2023.

These models of care pose both benefits and challenges to health care in the state. One such challenge is the proliferation of health care facilities across Pennsylvania, which is essentially unregulated. Under the Health Care Facilities Act of 1997, Pennsylvania established the Certificate of Need (CON) program to reduce duplication of services, fill gaps, and reduce overall health care expenditures. Through CON, health care providers seeking to make certain health care expenditures, build new facilities and beds, and establish new services had to first demonstrate "need" by the community for those proposed expenditures and services. On December 18, 1996, the CON provisions of the Act sunset (Longwell and Steele, 2011) and the Department of Health shifted to a community-based state health improvement assessment and planning process which has continued. Since then, Pennsylvania has seen an increase in the number of acute and specialty facilities, especially in the last five to 10 years. My office hears regularly from small rural hospitals leaders with their concerns about increased competition, potential or real loss of market share, and continued eligibility for, as an example, Critical Access Hospital designation.

The REH and OED models also pose challenges due to exclusion of inpatient bed capacity. Using Clinton County as an example, with the transition of UPMC Lock Haven from an acute care facility to an OED, the remaining hospital in the county with inpatient beds, Bucktail Medical Center in isolated Renovo, may see decreases in patient days due to patients being referred to or choosing to travel to Williamsport for hospitalizations. Studies have shown that patients may experience better outcomes when hospitalized locally and benefit from proximity to family and friends. Economic development also benefits from utilization of local health care

services since hospital payments create an economic "roll over" impact when they are reinvested locally by health care employees' purchases of goods and services. Rural health advocates promote utilizing and investing in the local health care system.

Rural Health Clinic Model

As part of this hearing, staff from the Pennsylvania Association of Community Health Centers has provided a comprehensive discussion of the Federally Qualified Health Center (FQHC) model of care. FQHCs serve as an essential component of the "safety net" system for patients who are un- or underinsured.

While FQHCs are located in all geographic locations, another critical part of the safety net system, the Rural Health Clinic (RHC), is rural-specific. The RHC program was established in 1977 at the federal level to increase the utilization of non-physician providers in rural areas while increasing access to care. Much like their FQHC counterparts, RHCs are paid an all-inclusive rate for patients with Medicare and Medicaid. Clinics may be independent or provider-based (i.e., linked to a hospital) and must be located in a rural area. RHCs are required to provide six basic laboratory tests and can furnish telehealth services.

Today, there are 69 RHCs delivering primary care to patients across rural Pennsylvania. While some specialty care can be provided, provision of primary care services is the primary focus of rural health clinics. Unlike FQHCs, RHCs are not required to provide dental services; however, due to community need, many RHCs have integrated oral health into their medical practice and a few facilities have dental hygienists and/or dentists on site.

Maternity Care in Rural Areas

One of the most alarming trends in rural health care is the reduction in access to labor and delivery services. From 2010 to January 2023, the number of rural hospitals eliminating obstetric services increased from 198 to 217 (Chartis, 2023). Since February 2023, 17 hospitals across the country have closed maternity and obstetric services (Becker's Healthcare, 2023), due to low numbers of delivery services performed each year; financial challenges, including the high cost of medical malpractice for obstetrical services; and staffing challenges (Hung, Kozhimannil,

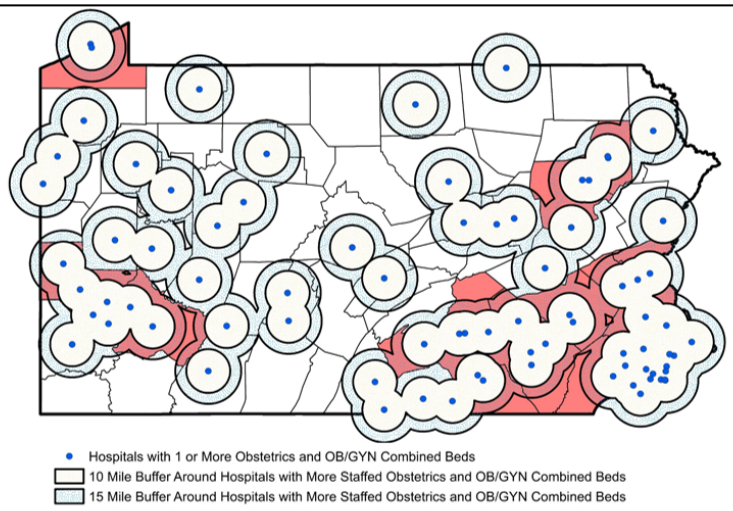
Casey, and Moscovice, 2016). These closures create or exacerbate maternity deserts in areas that need care the most (Becker's Healthcare, 2023).

Of the 119 maternity care deserts identified by the March of Dimes in the nation, four counties are in Pennsylvania: Cameron, Forest, Sullivan, and Wyoming, all of which do not have a hospital (March of Dimes, 2022). A report from the Center for Rural Pennsylvania indicated that 18 rural Pennsylvania counties are or are forecasted to be "maternity care deserts," where there are not enough providers to ensure access for all pregnant persons (Center for Rural Pennsylvania, 2022). Of Pennsylvania's 42 rural hospitals, 60 percent do not have labor and delivery services, according to an analysis from the Center for Healthcare Quality and Payment Reform. Of the 17 rural hospitals that maintain maternity wards, 35 percent reported financial losses on patient services (Healthcare Quality and Payment Reform, n.d.).

Many pregnant persons in rural areas need to drive almost 40 minutes to reach a hospital that can assist them during birth, which exceeds the recommended 30-minute travel time once a person begins labor (Healthcare Quality and Payment Reform, n.d.). These challenges also contribute to increases in births outside of hospitals, births in hospitals without OB units, and in preterm births, all of which carry greater risks for both mothers and newborns (Lewis, Paxton, and Zephyrin, 2019).

Figure 1 depicts the licensed hospitals with obstetric and gynecologic units in Pennsylvania and shows the areas of the state that have decreased access to these services, especially in the northern tier and the counties in the southwest and southcentral regions that border West Virginia and Maryland (Center for Rural Pennsylvania, 2022). The figure provides data for 10- and 15-mile buffer zones from each facility by rural and urban location.

Figure 1: Pennsylvania Hospitals with Staffed Obstetric and OB/GYN Combined Beds, by Rural/Urban Counties, 2020



	Rural	Urban
Residents Living Within 10 miles of Hospital with Obstetric & OB/GYN Beds	1.74 Million 51% of Rural Population	8.63 Million 90% of Urban Population
Residents Living Within 15 miles of Hospital with Obstetric & OB/GYN Beds	2.45 Million 72% of Rural Population	9.38 Million 98% of Urban Population

Source: Pennsylvania Department of Health and the U.S. Census Bureau; prepared by the Center for Rural Pennsylvania

In Pennsylvania, Medicaid is a major public source of financing health care services provided to pregnant persons, infants, and children and in 2020, 34.9 percent of mothers had Medicaid at the time of birth. In 2021, about 1 in 16 women of childbearing age (6.4 percent) was uninsured in Pennsylvania (March of Dimes, 2022). As of July 26, 2023, 138,000 Pennsylvania adults have been removed from Medicaid due to the "Medicaid unwinding" associated with the end of the Public Health Emergency (Kaiser Family Foundation, 2023). It is not known how many of these newly uninsured are persons who are pregnant or of child-bearing age, but it is anticipated that the number of persons in these categories will increase. Not-for-profit community hospitals are required to provide care to patients regardless of their insurance status and as a result, uninsured persons who deliver at those hospitals add to the overall cost of care and to the amount of uncompensated care provided.

Closing Comments

In July of this year, the Region 3 Office of the Centers for Medicare and Medicaid Services (CMS) conducted a "Rural Road Trip," and visited 11 health care facilities along the northern tier, from Muncy to Meadville. PORH staff attended to learn about the successes and challenges these providers encounter. The input was illuminating. Consistently, severe workforce shortages, significant reimbursement challenges, denials of care due to competing insurance plans, the provision of essential but non-billable services, lack of emergency service transport, and pharmacy closures are but a small sample of the concerns and frustrations voiced. Some hospitals stressed that they may, at any time, be days away from closing and many cited the commitment to providing high quality care regardless of the potential reimbursement because "it's the right thing to do." They continue to serve their communities because of, or despite, payment policies and state and federal agency support. Health care is a complex system of providers, payers, rules, and regulations. Hospitals, clinics, staff, and most importantly, patients, deserve all the support they can get.

To have an impact on rural health disparities, interventions must address three key elements—engaged patients, prepared practitioners, and community resources—each of which may have unique local or regional features. For interactions among these three elements to be most effective, there must be a common goal of population health improvement.

Addressing health disparities across all geographies and populations in the state is achieved through collaboration and cooperation. No one agency or organization can do this alone. Most of us present at this hearing have long-standing partnerships and are members of the Pennsylvania Provider Coalition coordinated by the Hospital and Healthsystem Association of Pennsylvania. Pennsylvania's health care advocates work closely with the Departments of Health, Human Services, Insurance, and other state agencies; statewide associations focused on a wide range of professions and services; educational institutions; and the community-based providers who are at the core of what we do. In my role, one of our most valued partners is the Center for Rural Pennsylvania with whom we share a common goal: a vibrant and healthy rural Pennsylvania.

Thank you for your interest in and commitment to addressing the health care needs of rural residents and communities and thank you for the opportunity to provide this testimony.

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