Testimony on rural healthcare services

Assembly Committee on Health

May 31, 2019

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Good morning Chairman Gottfried and members of the committee. I am here on behalf of the Healthcare Association of New York State, which represents nonprofit and public hospitals, health systems and continuing care providers across New York. We thank you for the opportunity to come before you today to discuss the critical issues impacting the millions of New Yorkers who live in, work in or visit our rural communities.

The legislature has been an important partner in advancing health policies and investments to support our rural healthcare providers and the patients they serve, and HANYS thanks the committee for your longstanding leadership of those efforts. Despite all of this good work, however, many of our rural hospitals and nursing homes and their critical partners, including emergency medical services agencies and home care providers, are struggling to survive.

The rural safety net

Across America, our rural hospitals are not only providers of emergency and inpatient care — they may be the only providers of primary care, dental services, mental healthcare and substance use disorder services in a county or region. They also play a critical role in the event of a natural or manmade disaster, keeping their doors open 24/7 to care for the injured and serving as places of refuge for those with nowhere to turn.

Nearly all of New York's rural hospitals have a special designation from the federal government, recognizing the urgency of sustaining these services: 18 are designated as Critical Access Hospitals; 19 are recognized as Sole Community Hospitals and three are Medicare Dependent Hospitals.

Our rural hospitals are also leaders in creating partnerships to address the social determinants of health, including developing senior housing projects, supporting access to healthy food, offering smoking cessation and linking patients to legal assistance.

At the same time, rural hospitals and nursing homes face unique challenges. They are often geographically isolated, making it difficult to recruit clinicians and other critical staff. Nationally, while 20% of the population resides in a rural area, only 10% of physicians practice in those communities. Rural hospitals have lower volumes of patients supporting fixed operating costs and they treat a population that is older, sicker and poorer than their urban counterparts. In addition, they serve a large share of patients covered by Medicare and Medicaid, both of which underpay for the cost of delivering care.

The issue of rural hospital closures has gained increased attention nationally. Researchers at the University of North Carolina have documented 106 rural hospital closures since 2010, many having severe consequences for their communities, especially in the most remote areas where patients may no longer have access to emergency care or maternity services. According to the Centers for Medicare and Medicaid Services, fewer than 50% of rural women nationwide have access to perinatal services within a 30-minute drive of their home.

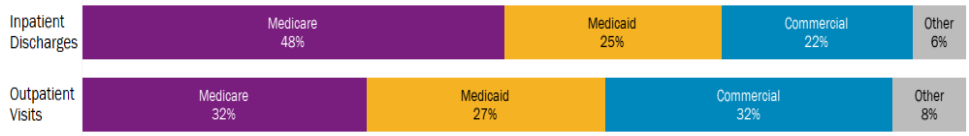
The loss of a hospital not only means loss of healthcare, but also the loss of jobs and the associated economic impact in a community. New York's 48 rural hospitals account for 50,190 jobs and an economic impact of $6.7 billion annually, according to a recent HANYS analysis.

In New York, innovative leadership and critical state support have, in many cases, managed to sustain essential services in the aftermath of rural hospital closures, but the loss of a community hospital can be devastating. HANYS has tracked the loss of eight rural hospitals in New York since 2008: in most communities impacted by these closures, essential services such as emergency care have been sustained, but the disruption and diminished access to other types of care can be painful to these communities and the stress on many of our fragile rural providers continues.

Need for payment adequacy

According to 2017 data, approximately 54% of New York's rural hospitals have a negative operating margin. Overall, the average margin for rural hospitals in New York is less than 1%, well short of the industry standard of maintaining a 4% margin to support reinvestment and stability. According to the National Rural Health Association, 44% of rural hospitals operate in the red nationwide. *Why?*

In New York, 73% of inpatient discharges and 59% of outpatient visits at rural hospitals are paid for by either Medicaid or Medicare (see figure below.) Yet, both these payers fail to adequately reimburse for the care delivered to their beneficiaries. According to a HANYS analysis, Medicaid pays 74 cents on the dollar for the care provided and Medicare pays 94 cents on the dollar.



This dependence on government payers makes rural hospitals vulnerable to variations in state and federal fiscal policy, which are difficult to predict. New York has made crucial investments in our rural hospitals through various transitional funding programs, but we also need to create an ongoing reimbursement system that fairly pays for the cost of quality care provided.

Workforce

Ensuring an adequate healthcare workforce in rural areas is a challenge in New York and across the nation. There is often a need for flexibility in the way services are provided in these areas due to a maldistribution or shortage of providers for a given specialty or service. Clinician shortages occur on every level of care from physicians (both in primary care and specialty services) to

registered nurses, respiratory therapists, laboratory techs, substance abuse counselors and others, depending on community needs and demographics. It is important for rural hospitals that providers are able to work at the top of their license to provide the highest quality of care to patients in a manner that is both accessible and affordable.

An emerging crisis: Rural EMS

HANYS has heard increasing concerns from our rural members regarding the state of emergency medical services. You may have seen news reports about the abrupt closures of ambulance services locally in the Capital Region. Last year, nearly 20 ambulance agencies shut down, according to the DOH Bureau of Emergency Medical Services.

The pre-hospital system is integral to the care of patients in our rural communities and disruption in those services is detrimental to outcomes, for obvious reasons. This is a particularly challenging issue given the array of emergency medical services provided by hundreds of agencies, with those operating in rural areas more dependent upon volunteers than their urban counterparts. Our EMS personnel are also on the front lines of addressing the opioid epidemic through administration of naloxone and otherwise tending to patients who have overdosed.

But as with any other healthcare service, payers need to adequately reimburse for the care provided. DOH recently studied the Medicaid rates for ambulance providers and found them sorely lacking, yet has not increased rates sufficiently to cover the costs of providing these services. Ensuring EMS providers are adequately paid for their core mission is essential to the continuation of services in rural areas. Additionally the state could provide for reimbursement of additional new services provided by EMS, such as transportation to locations other than a hospital, and/or allow for the practice of community paramedicine to be provided in certain circumstances to fill gaps in care when other providers are not available.

Laboratory personnel

There is a nationwide shortage of personnel to work in clinical laboratories, including clinicians at all levels of expertise, education and credentials. Shortages in all areas and on all levels have a domino effect by making the short-staffed labs unable to host clinical placements for those pursuing work in this field. Limited resources, sparse educational programs and rigid licensing requirements within the state further impede hospitals' ability to recruit and retain laboratory professionals. New York could address some of these challenges by streamlining the process within the State Education Department for assessing reciprocity of out-of-state training programs and for licensure for graduates of approved programs. New York could also allow certain supervisory responsibilities to be done via telemedicine. HANYS is working with our members to identify additional strategies to address this critical shortage.

Pharmacy technicians

A recent reinterpretation of state regulations regarding the role of pharmacy technicians in New York has created a strain on the workforce — taking pharmacists away from direct patient care to perform support functions. New York is one of only four states that do not recognize pharmacy technicians in statute or regulation. HANYS supports legislation that would recognize pharmacy technicians and clarify their roles in assisting pharmacists with preparing medications.

Telehealth

Telehealth is a promising development for addressing workforce shortages and getting needed healthcare services to underserved communities, particularly for specialty services, such as psychiatry. HANYS has long advocated for increased flexibility in state oversight of these innovative models, as long as appropriately credentialed personnel are providing these services.

While Medicaid has greatly expanded the types of services for which it will pay, there is still discord among the state agencies in terms of oversight and regulatory structure, posing challenges for providers seeking to evaluate the feasibility of a telemedicine program.

In New York, we have passed coverage parity for services provided via telemedicine but have not passed payment parity; as a result, payers are free to pay different rates when patients are treated remotely.

Regulatory flexibility

Regulatory flexibility authorized under the Delivery System Reform Incentive Payment program has enabled many of our rural providers to launch innovative programs to better serve their communities. Especially in the area of integration of services, regulatory waivers have paved the way to better use of limited resources to address patient needs. This flexibility should continue beyond the projected expiration date of the DSRIP program.

HANYS' recommendations:

- Support continuation of dedicated funding streams to recognize the unique role of rural hospitals in their communities.
- Support payment parity for healthcare services provided via telehealth/telemedicine and streamline regulatory oversight.
- Support funding to increase information technology capacity and infrastructure in rural communities for telehealth/telemedicine development, including addressing the lack of high-speed internet access in some areas.

- Support legislation (A.4561) to pay Critical Access Hospitals 101% of allowable costs (same as Medicare).
- Increase Medicaid payments to EMS providers to fully pay cost of providing services.
- Increase state funds for training support for potential EMS personnel and allow for innovative models of care, such as community paramedicine.
- Support increased flexibility in oversight of integrated primary care and behavioral health, including allowing social workers to bill in the Article 28 setting. This is critical given the severe shortage in behavioral health providers for rural areas.
- Support extension of the regulatory flexibility allowed under the DSRIP program.
- Streamline processes for evaluating out-of-state clinical laboratory training/educational programs and licensure of new laboratory professionals.
- Support legislation to recognize pharmacy technicians and authorize them to assist pharmacists in preparing and dispensing drugs.
- Support adequate funding for recruitment and retention of physicians, such as the Doctors Across New York practice support and loan repayment program.

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HANYS is committed to working with state government and all healthcare stakeholders as we pursue our common goal: ensuring that the highest quality care is accessible and affordable to all New Yorkers. We appreciate the support of the legislature and governor and look forward to continuing the progress we have made together.