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Before
The Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education and Related Agencies
May 7, 2015

Chairman Blunt, ranking member Murray, and members of the Subcommittee, thank you for the opportunity to testify today on rural health care issues.

I am Julie Petersen, CEO of PMH Medical Center in Prosser, Washington, a community of about 6,000 people in the south central part of the state.

PMH is a 25-bed critical access hospital (CAH) with an average daily census of approximately 15 acute, swing and obstetric patients. In addition to providing inpatient and outpatient hospital services, we also employ or contract with 27 physicians and providers in our clinics and hospital.

PMH has a rural health clinic that provides primary care, OB/GYN, medical pain management and limited dental services. We also provide both inpatient and outpatient general, orthopedic, podiatric, gynecological and ear, nose and throat surgical services through our provider-based surgical clinic. PMH provides Level IV trauma and Level III stroke team service.

In addition, PMH provides 24 hours a day, seven days a week emergency ambulance services to a large, multi-county region using two advance life support ambulances operating out of two stations. We also work closely with our local public health department, community health centers, and other local providers.

PMH operates as a public hospital district governed by a seven-member elected board. Our district serves roughly 68,000 rural residents in Benton and Yakima Counties. In addition to the services we provide in Prosser, we operate satellite facilities throughout the sparsely-populated parts of our district.

The Good News
There is a lot of excellent health care work being done in the state of Washington, much of it with the support of the federal government.

Washington State hospitals have been recognized as national leaders in increasing the quality and safety of care in our hospitals. We believe that rural hospitals can and should provide the same high quality care that our larger hospitals provide. Our state's rural hospitals are fully invested in the quality improvement work being advanced collaboratively. We also believe this work must be measured and reported.

Over the last several years, the Washington State Hospital Association (WSHA) has received $18 million in federal funds to participate in the Hospital Engagement Network/Partnership for Patients initiative established by the Centers for Medicare & Medicaid Services (CMS).

This initiative is a public-private partnership working to improve the quality, safety, and affordability of health care for all Americans. The program focuses on making hospital care safer, more reliable, and less costly. In Washington, we have used the funding to come together and share best practices, hire national experts to teach us, report and analyze data to motivate performance, and educate patients.

The return on investment for this program has been enormous: $235 million in reduced health care spending.

For example, the state's hospital readmission rate fell dramatically, by almost 12,000, saving more than $110 million. About $10 million was saved by quickly reducing early elective baby deliveries, which can result in harmful and expensive complications.

The program also helped us prevent 23,000 potentially harmful events to patients, including:

- An 89 percent reduction in ventilator-associated pneumonia,
- A 60 percent reduction in pressure ulcers,
- A 38 percent reduction in severe sepsis and septic shock mortality resulting in 175 lives saved,
- 17 percent reduction – 42 fewer – in Clostridium difficile infections, and
- A 13 percent reduction in catheter-associated blood stream infections.

We greatly appreciate Congress's investment in the Partnership for Patients program and encourage you to keep investing in it. We believe you will continue to see similar return on investment.

In addition to these statewide accomplishments, PMH was awarded a $1.5 million grant from the Center for Medicare & Medicaid Innovation (CMMI) for three years. This program utilizes a case manager and the paramedics and EMTs that staff our 911 service to visit patients who have recently been discharged from the hospital, fragile emergency department patients, and to perform follow-up after surgery.

This team works with primary care physicians, home health agencies and family to confirm follow-up appointments, review medications and ensure discharge instructions are being followed. We have seen a reduction in readmissions to the hospital as a result of the program.

Recently, Washington State was also awarded a $65 million CMMI grant to transform health care. Called Healthier Washington, the initiative invests in forming connections and active collaboration with Washington's communities, partners and providers to achieve better health, better care, and lower costs.

The initiative's areas of focus include:

- Community empowerment and accountability,
- Redesign of clinical practice,
- Payment redesign, including developing a new payment model for rural care providers, and
- Analytics, interoperability and measurement.

The initiative seeks to improve the care of patients while reducing costs. For example, the initiative will test clinical care models integrating physical and behavioral health for the state's primary care and rural health delivery system.

Challenges Facing Critical Access Hospitals

But while we have much to be proud of, we face serious challenges, as well.

While Washington State has some large population centers such as Spokane and Seattle, a vast amount of our state's land is used for agriculture. In fact, 31 of Washington's 39 counties are considered rural.

PMH is typical of the health care organizations that serve rural areas. These organizations represent, in many cases, the entire health care delivery system – providing access to a broad spectrum of health care services from primary care to hospice, home health and emergency ambulance services. Their continued viability is critical to the health, welfare and economic viability of these communities.

This has always been a difficult challenge – but, in recent years, it has become even more so.

Characteristics of Rural Populations

Rural communities often have large uninsured and low-income populations. In Yakima County, 25 percent of the population was uninsured in 2012, compared to about 17 percent statewide. Thirty-four percent of the adults in the county were uninsured.

One reason for the higher uninsured rate is that, compared to urban counties, there are fewer large employers in rural areas who provide medical benefits. In addition, many of the uninsured were agricultural workers who work in seasonal jobs.

This population still gets sick, still has babies and still suffers accidents. But, because they did not have insurance, they often did not have a primary care provider and put off routine primary care. That means that when they do need medical attention, they use PMH's emergency room – the most expensive venue for care.

And, because these patients have not been able to pay their medical bills, the cost of their care is passed on to privately-insured individuals in the form of higher insurance premiums.

Rural communities also have greater concentrations of older residents. It is not uncommon in rural hospitals for 80 percent of a hospital's patients to be covered by Medicare and/or Medicaid.

Medicare and Medicaid enrollees are often sicker, can suffer from a number of chronic conditions, and, compared to a healthy 30 year old population, require more expensive medical procedures. This puts extra demands on the delivery system.

In general, the health status of people in rural areas is not nearly as good as in urban areas. For example, according to Washington State Department of Health data, mortality rates are higher in rural areas. Rates for three of the top causes of death – stroke, unintentional injury and self-harm – are higher and increasing rapidly in rural communities. The number of adults who are overweight or obese is also consistently higher in rural areas.

This is especially true in parts of our market area. For example, in Yakima County, diabetes, obesity, and infant and child mortality all exceed the state average. The premature death rate is 26 percent higher than statewide; sexually-transmitted infections are 46 percent higher; and the teen birth rate is twice the state average.

These circumstances present special challenges to providers and can dramatically increase the need for medical services.

Workforce Shortages

In addition, we face workforce shortages in rural areas. Physician recruitment is a full-time job for me and my colleagues. And once we've recruited physicians, keeping them here is even more important. Physicians in rural areas are still routinely required to participate in on-call rotations. That is no longer the case in many urban and suburban settings and can greatly affect a physician's work-life balance.

Our providers – especially those in anesthesia, surgery, the emergency department and primary care – actually work longer hours, including a 24-hour call. They also often work in multiple locations. In primary care, physicians see far more complex patients than their urban counterparts.

Rural hospitals and health clinics also face constant struggles to retain nurses and the other health professionals we need to keep our doors open.

Making matters worse, we have an aging workforce, so keeping the workforce pipeline open and running smoothly is critically important to us. That's especially true for specialty nurses like those who are trained for emergency services and labor and delivery.

Rural health systems, like mine, compete in a national labor market, which means we pay top dollar for primary care doctors, nurses and other health professionals.

Wages and salaries for the health care professionals and other workers at PMH account for more than 68 percent of our organization's costs. So, paying national labor rates contributes significantly to the overall cost of care in our community.

Costs of Delivering Services

The cost of prescription drugs, technology and health information technology, like electronic health records, also drives up the cost of medical treatment in Prosser and other rural communities.

PMH participates in the 340B drug discount program, as do 29 of Washington's 39 CAHs. This program, which was expanded in the Affordable Care Act to include CAHs, enables us to provide affordable prescription drugs to patients who otherwise would not be able to obtain them.

Financing Health Care

Finally, reimbursement models often don't suit sparsely-populated communities like mine. Similar to most CAHs, PMH is an integrated health system. As I noted before, we provide a broad spectrum of services to our community.

Unfortunately, Medicare reimbursement policies fail to recognize this reality. Separate and distinct policies govern reimbursement for hospital, physician, skilled nursing, home health, hospice and other services. While CAHs are paid 101 percent of their allowable costs for hospital services – actually 99 percent after sequestration – payments for these other non-hospital services are not nearly high enough to pay for the true cost of care.

Because of the wide variety of services we provide, we are reimbursed in a myriad of different ways – from fee-for-service to encounter rates, per-diem rates (or daily rates) and percentages of payment based on the cost of providing care.

We also face conflicting incentives and regulations. For example, keeping a patient for more than two midnights but not more than 96 hours and not knowing at the time of admission whether the patient will stay longer than 48 hours but fewer than 96 hours complicates care planning even more.

The two midnight and 96 hour rules are both recent CMS clarifications and changes in policies that impact our reimbursement.

With advances in technology and treatment techniques, inpatient hospital revenue as a percentage of total revenue for health care organizations continues to shrink. This is especially important at PMH where inpatient hospital services account for only 27 percent of the organization's revenues. As the demands for health care change and more services are performed outside of the hospital, payment models should recognize this shift.

In addition, increasingly complex regulatory requirements have added considerable costs to our administrative structure. Too often, we are expected to comply with rules that may make sense in large urban areas but do not fit the models of care in our rural communities.

In this environment, it is increasingly difficult for rural health systems to remain financially viable and to continue to provide the services their communities need.

Increasing Health Care Coverage

As I mentioned above, the large uninsured populations in parts of our state – including Benton and Yakima counties – has been a major concern for us. That's why hospitals strongly supported efforts to expand Medicaid eligibility and to operate a state-run health insurance exchange.

The availability of coverage through the state's health insurance exchange and through the expansion of Medicaid has led to a dramatic reduction in the number of uninsured Washingtonians. Statewide, the percentage of residents without some sort of insurance has fallen from about 17 percent to 11 percent according to a recent Gallup poll.

Medicaid expansion has resulted in about 7 percent of the state's population enrolling in the program. That's nearly 535,000 residents who now have health coverage and includes more than 5,000 residents of Benton County – about 3 percent of the county's population.

By April 18, 2015, the Health Benefits Exchange had enrolled 170,000 people in individual insurance plans with almost four of five people who bought coverage through the Exchange receiving some subsidy to help pay the cost of monthly insurance premiums.

In Benton County, 3,285 people enrolled in plans though the Exchange, about 2 percent of the population, and 2,660 of them received subsidies. In Yakima County, 4,160 people were enrolled in Exchange plans, and 3,630 of them received subsidies.

For the two open enrollment periods for plan years 2014 and 2015, the Exchange had a robust outreach and enrollment program. During the open enrollment period for 2015, the Exchange supported 1,400 navigators.

In addition, hospitals across the state supported outreach and enrollment efforts employing 240 in-person assisters. In Benton County, I want to applaud the work done by our navigators. They not only

enrolled people, but educated them about how to use health insurance and why it is important to have a primary care physician.

Medicaid expansion and the development of the insurance exchange has had a dramatic impact on PMH. For example, in just one year, our clinic visits increased by 27 percent. Our hospital is busier than it has ever been. The simple math of cost-based reimbursement is decreasing our cost per beneficiary.

In the first quarter of 2015 – compared to the same period a year ago – our adjusted patient days are up 40 percent while our cost per patient day is down 27 percent.

Uncompensated care is another indicator of the impact of coverage expansion. In 2013, as a percentage of revenue, uncompensated care – care for low-income patients that was provided at no cost or with financial assistance – was 7.1 percent. By 2014, it had shrunk to 4.5 percent.

We are seeing new patients who are using their health insurance coverage to see primary care providers – often for the first time. Access to preventive care, routine examinations, and diagnosing chronic conditions are possible for thousands of Washingtonians now because of insurance subsidies and expansion of Medicaid coverage.

Our goal now is to get them into an organized system of care that helps them avoid illness in the first place, and, when they do get sick, treats them early. Achieving all these goals is vastly easier when people have insurance.

We are also working to develop medical home models around the state to ensure care is coordinated and health care resources are used wisely. And hospitals like mine are collaborating on a wide variety of other projects ranging from group purchasing of supplies to sharing physician and clinic facilities.

In the long run, I am confident this new access to primary care will create a healthier, more productive population and help people avoid costly hospitalization and other medical procedures.

Finally, it is important to acknowledge that there is a cost for coverage expansion. The Affordable Care Act (ACA) reduced Medicare and Medicaid payments to hospitals across the U.S. to help pay that cost. Washington hospitals' share of that reduction was roughly $4 billion over 10 years.

Workforce Development

The state of Washington has made major investments in programs to train physicians and other providers, and we offer a number of high quality programs. However, shortages of many types of health care providers – and especially physicians – remain acute in rural Washington.

In my view, workforce development is a partnership between the public sector – the state of Washington and the federal government – and providers. In our state, this partnership has worked well, in large part, because a number of federal programs – mainly operated through the Health Services and Resources Administration (HRSA) – provide us with tools that help us address our workforce needs.

For example, for years, the National Health Service Corps (NHSC) has been a critically important source for physicians in rural and underserved areas. A significant number of these physicians – two thirds after one year – have stayed in the state after completing their tour, according to a 2012 study.

Right now, there are 248 NHSC participants in 143 sites in Washington. The program provides some $5.8 million in FY 2014 in loan forgiveness and scholarships to bring these physicians to underserved areas of our state.

The ACA extended funding for this program and the recently-enacted Medicare Access and CHIP Reauthorization Act of 2015 extended these funds further.

Our state also benefits from the Teaching Health Centers program authorized in the ACA, receiving $6.3 million over the 2014 – 2015 period. This program trains residents – about 28 per year – in community health centers and other non-hospital settings.

An overwhelming majority of residents practice permanently near where they did their residency, so investing in these programs is especially important.

HRSA has also provided nearly $6.4 million in funds to train nurses and allied health professionals.

These federal workforce training programs complement the investments made by hospitals and the state of Washington. I strongly encourage the subcommittee to continue these invaluable investments.

The Future of Rural Health

The third bucket of challenges facing rural health focuses on long-term issues facing all of us in rural America. HRSA funds several programs important to the work of the Critical Access Hospitals (CAH) in our state.

The Rural Hospital Flexibility Grant Program, established in 1997 when the CAH designation was created, has provided invaluable resources to small rural and frontier communities as they strive to preserve access to medical care.

The state of Washington receives a little less than $600,000 a year from this program, which it is using to help CAHs improve the quality of the care they provide, better manage chronic diseases, improve emergency response to heart attacks and strokes, and strengthen their overall performance.

The Small Hospital Improvement Program has helped rural hospitals prepare for implementation of ICD-10 and implement quality improvement reporting.

These funds play a significant role in the operation of a CAH. They help ensure high quality care, but they also enable these cash-poor facilities to respond to the regulatory and administrative requirements they face.

I also want to highlight the collaborative work in the state of Washington that is funded by the Federal Office of Rural Health Policy for rural health network planning, development and outreach.

The first grant awardee is the Critical Access Hospital Network comprised of 12 CAHs and 20 rural health clinics. This network will receive $876,000 over three years to integrate primary care and behavioral health, and to improve chronic care delivery using health information technology. It will also work to develop a shared health information technology infrastructure link to a common dataset to reduce chronic disease.

For example, all primary care clinics are working on reduction of hypertension by measuring the percentage of patients able to manage their blood pressure and targeting quality improvements.

The second grant awardee, in which PMH is a participant, is the Washington Rural Health Collaborative made up of 13 public hospital district CAHs and 18 rural health clinics. The collaborative received $864,000 over three years to develop and implement a system to benchmark quality and financial indicators and to position the 13 CAHs for participation in accountable care organizations and value-based purchasing.

As an independent hospital, it is challenging to be ready to participate in new clinical and payment models. Collaboration is one key to successfully developing these new models. The Collaborative and the Network are two examples of effective collaboration.

Also important to highlight is the role that the State Office of Rural Health plays in facilitating these rural collaborative efforts. The office provides the infrastructure that helps local rural communities implement new models for CAHs.

The office also provides the communication and technical assistance link between the federal government and local communities. State Office of Rural Health funds are matched three times by the state, creating a unique federal/state/local investment and partnership.

New Models for Rural Health Care

Additional work is also underway in our state to develop a new model for the most vulnerable CAHs. The Washington State Hospital Association (WSHA), a private nonprofit trade association of 99 hospitals, has identified 10 to 12 CAHs that could close their doors in the near future unless they receive payment flexibility and relief.

WSHA, the Washington State Department of Health, the Washington State Health Care Authority and several groups of providers are actively seeking to identify the appropriate model for ensuring that residents of these most vulnerable rural areas continue to have access to affordable health care services.

The Centers for Medicare and Medicaid Innovation has made an invaluable contribution to this effort – a $65 million award to transform health care delivery in the state of Washington. A small portion of these dollars will be used to develop a new payment method for these vulnerable CAHs.

The CAH model preserved access to hospital and clinic services in many rural and frontier communities, but it is not working in all situations. Changing utilization patterns – the shift from inpatient to outpatient and post-acute care – and low volumes of patients, especially commercially insured, have put financial strain on some CAHs.

A new payment model would not only change how we pay for health care, but should also adapt the current delivery system to better meet the unique needs of these communities. Thanks to the state of Washington's recent CMMI grant, we hope to develop such a model that can be tested starting in the next 12 to 18 months.

For a new model to succeed, we cannot be bound by the strictures of the past, but must look for new ways to create the flexible regulatory environment needed to design new options for rural health care. I strongly encourage the Federal Office of Rural Health Policy and CMS to work together to help us develop these new and innovative models.

Conclusion

As a CAH administrator, I'm very proud of the quality of the care we provide in Washington's small hospitals. We are working hard – in part with federal funding – to improve quality and patient safety even more. That means identifying quality indicators that reflect the care we actually provide and developing a value-based system that reflects the services available in our facilities.

The Federal Office of Rural Health Policy and the Washington Office of Rural Health have been invaluable partners in this journey. Federal funding has made a material difference in our ability to provide high quality care to people in our communities.

As a person who has worked almost her entire career in rural health care, I am dedicated to ensuring that the people who live in rural communities have access to the highest quality, affordable medical treatment.

I am optimistic that we will be able to achieve this goal. The programs we have discussed at this hearing go a long way toward getting us there, but much more remains to be done. I look forward to working with policymakers as we move forward.

Thank you for your attention and for this opportunity to speak to you today.