



## AMERICA'S ESSENTIAL HOSPITALS

November 27, 2019

The Honorable Richie Neal  
Chairman  
Committee on Ways and Means  
Washington, DC 20515

The Honorable Kevin Brady  
Ranking Member  
Committee on Ways and Means  
Washington, DC 20515

The Honorable Danny Davis  
Committee on Ways and Means  
Washington, DC 20515

The Honorable Brad Wenstrup  
Committee on Ways and Means  
Washington, DC 20515

The Honorable Terri Sewell  
Committee on Ways and Means  
Washington, DC 20515

The Honorable Jodey Arrington  
Committee on Ways and Means  
Washington, DC 20515

Dear Chairman Neal, Ranking Member Brady, and Reps. Davis, Sewell, Wenstrup, and Arrington:

On behalf of our more than 300 member hospitals, America's Essential Hospitals is pleased to respond to the Rural and Underserved Communities Health Task Force Request for Information (RFI). We appreciate the Ways and Means Committee's leadership in examining the factors that challenge the health of underserved populations, and we look forward to partnering with you to identify and develop policies to achieve health equity for all people.

America's Essential Hospitals is the leading association and champion for hospitals dedicated to high-quality care for all, including the most vulnerable patients. They fill a vital role in communities by providing a disproportionate share of the nation's uncompensated care—about three-quarters of inpatient discharges and outpatient visits at essential hospitals are uninsured, Medicare, or Medicaid patients.

Essential hospitals operate in a broad variety of communities—from the nation's largest cities to expansive rural regions—and all face significant social and economic challenges. Our member hospitals serve communities where need is greatest, where 360,000 individuals struggle with homelessness, 10 million people have limited access to nutritious food, and more than 17 million are uninsured. They have led the response to these social determinants of health by partnering with community leaders and local organizations to support social interventions, including food

pantries and demonstration kitchens, respite centers, employment assistance, community improvement projects, school-based health centers, and others. Essential hospitals know social determinants can threaten personal health, and confronting them gives essential hospitals an opportunity to improve population health overall and to use limited resources more efficiently to bend the cost curve in a meaningful way.

The extraordinary and innovative initiatives our members undertake to mitigate health risk factors and improve population health outcomes in rural and urban underserved communities inform our responses to these questions:

**1. What are the main health care–related factors that influence patient outcomes in rural and/or urban underserved areas? Are there additional systems or factors outside of the health care industry that influence health outcomes within these communities?**

As providers of care to vulnerable populations, essential hospitals are uniquely positioned to tackle complex clinical and social needs. Despite limited means, they reach outside their walls and into the community to influence factors beyond clinical care that affect a person's health, including housing instability, food insecurity, lack of access to transportation, and interpersonal violence. Research has linked these factors to adverse physical and mental health outcomes. Not addressing these issues, some of which can be mitigated through public health interventions, adds costs to both the health care system and local communities.

An essential hospital in Florida took a proactive approach to impact malnutrition in food deserts by providing weekly meal delivery to patient's homes after discharge. Staff education, screening, consultation with a registered dietitian, and coordination with long-term, community-based programs resulted in 28,879 patients screened and 1,352 patients receiving the full four weeks of meals. Patients completing the program had lower readmission rates than the average Medicare patient for stroke, sepsis, heart failure, acute myocardial infarction, and chronic obstructive pulmonary disease. The program facilitated higher-value care, as patients completing the program had an initial length of stay and total cost less than patients who did not participate in the program.

An essential hospital in Texas partners with the local Salvation Army and a large Medicaid services provider to offer permanent housing rental assistance and long-term comprehensive case management, with medical and supportive services, for medically vulnerable homeless patients with high emergency department (ED) utilization.

**2. What successful models show a demonstrable, positive impact on health outcomes within rural or underserved communities, for example initiatives that address: a) social determinants of health (particularly transportation, housing instability, food insecurity); b) multiple chronic conditions; c) broadband access; or d) the use of telehealth/telemedicine/telemonitoring?**

Essential hospitals' commitment to caring for all people makes them adept in understanding and responding to community needs. An essential hospital in Illinois partnered with a local nonprofit to create a housing collaborative, providing supportive housing for homeless patients with mental illness and substance use disorders. This program reduced internal health care costs by 21 percent, ED utilization by 45 percent, and inpatient admissions by 55 percent.

Essential hospitals also lead the way in telehealth initiatives and innovations to meet complex care needs and improve overall population health. Populations experiencing financial, housing, and food insecurity often face higher rates of chronic conditions and comorbid conditions. Research shows that telehealth is effective at expanding access for these populations while simultaneously reducing costs and readmissions. Cutting-edge, connected care services, such as remote patient monitoring or mobile health applications, have been used to respond to a variety of health challenges, including diabetes management and opioid dependency. For example, an essential hospital in Mississippi partnered with a mobile broadband provider to remotely monitor diabetes patients in rural Mississippi via tablet computers. Results of this pilot included a marked decrease in blood glucose levels, early recognition of diabetes-related eye disease, and no diabetes-related hospitalizations or ED visits among the patients in the pilot. The pilot also produced nearly \$700,000 in annual savings due to reductions in hospital readmissions alone.

**4. What lessons can we glean from service line reduction or elimination in hospitals that serve underserved communities where —**

**a. patients have the option to transition to alternative care sites, including community health centers and federally qualified health centers?**

**b. there is broader investment in primary care or public health?**

**c. the cause is related to a lack of flexibility in health care delivery or payment?**

Off-campus provider-based departments (PBDs) enable essential hospitals to expand access for disadvantaged patients in communities with no other options for basic and complex health care needs. The high cost of providing care to low-income and uninsured patients leaves essential hospitals with limited resources, driving them to find increasingly efficient health care strategies to remain open and accessible to the community. Restrictions in funding resources that enable essential hospitals to provide ambulatory care through PBDs can undermine access to critical care in these communities.

Essential hospital PBDs often are the only clinics in low-income communities that provide the full range of primary and specialty services. While federally qualified health centers provide much-needed access to primary care, patients with multiple chronic and challenging medical conditions often seek care in the clinics affiliated with essential hospitals, which have long experience in providing specialized, lifesaving services to complex patients.

Given essential hospitals' expansive networks of ambulatory care in otherwise underserved communities, site-neutral payments have a profound negative effect on

their patients. In most communities, essential hospitals are the only providers willing to take on the financial risk of providing comprehensive care to low-income patients, including the uninsured and dual-eligible beneficiaries.

Essential hospitals can help drive down overall health care costs by efficiently providing coordinated care through ambulatory networks. Providing care in the outpatient setting allows hospitals to avoid unnecessary ED visits, manage patients with chronic conditions, provide follow-up care to patients to avoid readmissions, and reduce costs for the health care system at large.

**5. If states or health systems have formed regional networks of care, leveraging for example systems of transport or the use of telehealth/telemedicine, what states or entities are these, what approaches did they use to form these networks, what challenges did they overcome, and what challenges persist?**

Essential hospitals are rooted in their community as a trusted and central resource for care. Partnering on certain initiatives and opportunities can help break down silos and enhance their ability to collectively provide equitable and efficient care delivery in their communities.

To improve health outcomes for residents in North Philadelphia, essential hospitals in Pennsylvania teamed up with schools and community organizations to form the North Philadelphia Health Enterprise Zone (HEZ). The initiative, launched in 2016, focuses on four key factors: health, community, education, and technology. Hospitals in the region struggled to share data across different electronic health record platforms. Hospitals supporting the HEZ now participate in the regional health information exchange, HealthShare Exchange, which allows real-time information sharing among care providers, reducing unnecessary or repeat procedures and driving down hospital costs.

CAPriCORN, the Chicago Area Patient-Centered Outcomes Research Network, offers another example of collaboration among health institutions, including essential hospitals, that put aside competitive concerns to share evidence-based research data. The alliance includes academic medical centers, industry associations, patient advocacy groups, insurers, government agencies, universities, and research institutes. CAPriCORN is designed to overcome the barriers of care fragmentation and limited resources to develop, test, and implement strategies to improve care for diverse populations and reduce health disparities. This initiative was born of the Patient-Centered Outcomes Research Institute.

**6. What successful models show a demonstrable, positive impact on addressing workforce shortages in rural and underserved areas? What makes these models successful?**

Essential hospitals are dedicated to developing the future health care workforce. Our members train three times as many physicians as other U.S. teaching hospitals. Nearly one in 10 allied health professionals who trained in an acute-care facility did so at an essential hospital.

Practicing in underserved communities requires a unique set of skills that include training in culturally competent care and an understanding of the challenges and social risk factors vulnerable communities face. For example, essential hospitals recognize that responding to the opioid crisis requires a well-trained workforce. To this end, essential hospitals provide psychiatric residency programs tailored to develop needed skillsets in behavioral health and substance use disorder to fight the opioid crisis.

But these training programs come at significant cost to essential hospitals. Despite operating on razor-thin margins—1.6 percent on average compared with a nearly 8 percent average nationally—our members train nearly five times more physicians beyond federal graduate medical education funding caps than other U.S. teaching hospitals. They receive no federal funding for residents they train above their cap, even though they incur higher costs than the average hospital by virtue of their patients and the complexity of the services they provide.

New physicians tend to stay close to where they are trained, and essential hospitals operate in areas of highest need. Our members have the experience and expertise to train providers but lack the resources necessary to further expand their training programs to meet the growing workforce needs of the populations they serve.

**7. Access to providers that address oral, behavioral, and substance use needs in rural and underserved communities can be particularly limited. What approaches have communities or states taken to address such gaps in care delivery?**

Essential hospitals are on the front lines of the response to the opioid crisis. To expand behavioral health and substance use disorder treatment in rural areas, where fewer providers are waived to provide medication-assisted treatment (MAT), essential hospitals have relied on telemedicine. One essential hospital in West Virginia developed the comprehensive opioid addiction treatment (COAT) program to use telemedicine to reach into rural areas with no other providers and to connect patients with MAT. We appreciate Congress' efforts as part of the "Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act" to expand the use to telehealth and telemedicine to treat substance use disorders in underserved communities, which will help expand access to lifesaving care.

It is critical to note that, more broadly, a stable Medicaid program is essential to supporting underserved communities. States rely on the Medicaid program's flexibility to address public health needs, including the opioid crisis, disease outbreaks, or other unexpected community health issues, in real time. Any instability in the Medicaid program—for example, through reductions in disproportionate share hospital (DSH) payments and limits on how a state may finance its share of Medicaid—will hamper a state's ability to meet behavioral and substance use needs in rural and underserved communities. Given that more than half of our members' inpatient and outpatient care is provided to Medicaid and

uninsured patients, any systematic erosion of the social safety net would hit hardest essential hospitals and the vulnerable communities they serve.

**9. There are known, longstanding issues with the availability and integrity of data related to rural and urban community health. What data definitions or data elements are needed to help researchers better identify the causes of health disparities in rural and underserved areas, but are unavailable or lack uniformity?**

America's Essential Hospitals appreciates that Congress acknowledges the need for additional policy recognition for the socioeconomic factors that affect vulnerable people who receive hospital care.

Risk adjustment, for example, is critical to ensuring collected hospital data reflects the realities of care for underserved populations. Peer grouping hospitals by their number of dual-eligible patients, as required by the 21st Century Cures Act and implemented by the Centers for Medicare & Medicaid Services (CMS) in the Hospital Readmissions Reduction Program for fiscal year (FY) 2019, is a solid first step toward true risk adjustment for hospitals treating vulnerable patients. Beyond dual-eligible status, policymakers might consider differences among patients' background, such as language, post-discharge support, and sociodemographic status, that could affect readmission rates and incorporate these factors in its risk adjustment methodology.

Congress also could encourage CMS to use its existing authorities to collect social determinants of health-related data in manners that do not burden essential hospitals. For example, in its proposed inpatient payment rule for FY 2020, CMS recommended changing the severity level designation of the ICD-10 code for homelessness (Z59) from a non-comorbid condition to a comorbid condition. CMS cited data suggesting that when the Z59 diagnosis code is reported as a secondary diagnosis, the resources involved in caring for the patient justify increasing the severity level. Although CMS chose not to finalize this change for FY 2020, we support this approach. We encourage Congress to engage with CMS on these types of data collection adjustments through existing collection mechanisms.

**10. Are there two or three institutional, policy, or programmatic efforts needed to further strengthen patient safety and care quality in health systems that provide care to rural and underserved populations?**

To accurately promote quality care and empower patients in health care decision-making, federal quality reporting programs should reflect the unique circumstances of essential hospitals and their communities.

Hospital overall star ratings, for example, were developed to summarize Hospital Compare quality measures in a consumer-friendly way, yet increasingly are used as a measure of overall hospital quality. America's Essential Hospitals supports sharing meaningful hospital quality information with patients. However, we believe there is the distinct risk that larger hospitals, teaching hospitals, and hospitals serving a

high proportion of low-income patients are receiving lower star ratings despite providing quality care, often to the most vulnerable patients.

America's Essential Hospitals has shared our star rating methodological concerns with CMS and encourages Congress to work with the agency to avoid confusion among patients, as well as any disproportionate effect on essential hospitals.

Similarly, the Hospital Consumer Assessment of Healthcare Providers and Systems survey results are a component of the Hospital Value-Based Purchasing (VBP) program, which rewards hospitals based on the quality of care provided to Medicare patients, including patients' experiences of care during hospital stays. Essential Hospitals Institute research, corroborated by independent, peer-reviewed studies, suggested that factors not within hospitals' control might be more responsible for the distribution and allocation of penalties under the VBP program than factors within their control. Policymakers should structure incentives in a way that accounts for factors affecting the measurement of patient experience, promote equity, and reward continued improvement.

Accurate quality measures ultimately benefit patients, particularly the most vulnerable.

Thank you for your leadership. We look forward to helping you develop and advance important legislation to help our members further achieve their mission to improve the overall health of the communities they serve. If you have questions, please contact Vice President of Legislative Affairs Carlos Jackson at [cjackson@essentialhospitals.org](mailto:cjackson@essentialhospitals.org) or 202-585-0112.

Sincerely,

/s/

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