House Hearing COVID – 19 *Disproportionate Impact on Communities of Color*

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The Disproportionate Health Impact on Non-COVID Patients during the Pandemic

My name is Gwendolyn R. Majette, J.D., LL.M. I am an Associate Professor of Law at Cleveland-Marshall College of Law in Cleveland, Ohio. I am a recognized scholar who writes on Health Care Disparities and have been working on these issues for 17 years. I also teach courses about our health care system including Health Law, Health Care Finance, Law and Medicine, and Health Legislation, Regulation and Policy. I have also taught at American University School of Law, John Hopkins Business School, and Howard University School of Law and School of Medicine. My statement is my own and should not be attributed to those institutions.

My written testimony will focus on disparities in post-acute care for the Medicare elderly. I would like to provide some context for my testimony. Twelve years ago, I had the privilege to work on Capitol Hill as a Fellow with the Health Subcommittee of Ways and Means in Chairman Pete Stark's office. At that time, Congress was considering major health care reform legislation. I also attended the historic hearing "Addressing Disparities in Health and Health Care Issues of Reform" on June 20, 2008.

My work as well as others highlights the causes of health disparities for people of color.[1] In the U.S. health care system, disparities exist with respect to access to providers (individuals and facilities) in communities of color; the ability to pay for needed health care; the quality of care provided; and disparate treatment because of stereotyping, bias, and discrimination. The Affordable Care Act included many provisions designed to eliminate health disparities for people of color and other vulnerable groups. I identify and analyze those provisions which I collectively call the "*PPACA Framework to Eliminate Healthcare Disparities."* [2] Some of those provisions

[1] Gwendolyn Roberts Majette, *Access to Health Care: What a Difference Shades of Color Make*, 12 Annals Health L. 121 (2003), *cited in* Furrow, Greaney, Johnson, Jost, and Schwartz, HEALTH LAW at 598 (6th ed. 2008); Adler, N. E., D. M. Cutler, J. E. Fielding, S. Galea, M. M. Glymour, H. K. Koh, and D. Satcher. *Addressing Social Determinants of Health and Health Disparities: A Vital Direction for Health and Health Care*. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC (2016).

[2] Gwendolyn Roberts Majette, *Global Health Law Norms and the PPACA Framework to Eliminate Health Disparities,* 55 How. L. J. 887 (Spring 2012).

have been challenged and weakened during the last three years which undermines a systematic approach to eliminate health disparities for vulnerable groups.[3]

This statement will highlight equity issues with respect to access to post-acute care for non-covid patients. How should our health care system be designed to care for patients who need intense care after their hospitalization during the COVID-19 pandemic? Pre-COVID, those individuals would be discharged to a rehabilitation facility or skilled nursing home. But during the COVID-19 pandemic, the nursing homes and rehabilitation facilities became high risk places to receive care.[4] This is especially so for facilities caring for patients of color. Given the concern that COVID-19 might spread to nursing home residents, some health care providers have advocated that high-intensity post acute care should be moved to the home.[5] Implementing this recommendation can be difficult.

Caring for high-intensity patients at home can be a challenge for people of color and the poor. Do families have the health care literacy to safely care for their recuperating family member? Have families been trained to provide the necessary care? Do families have the financial resources to pay for in-home providers? Do families have flexible work schedules to take time off to care for their family? Will family members be able to access the appropriate medical equipment, including durable medical equipment for their family members?

Some legal scholars have highlighted concerns about shifting post acute care to the families prior to the pandemic.[6] The COVID pandemic stresses many families creating fragile family structures that might not be able to handle caring for a family member that needs intense care. The pandemic has also stressed the availability of health care providers. There are many reasons for this including the shortages created because health care providers themselves became

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[3] Gwendolyn Roberts Majette, *Striving for the Mountaintop – The Elimination of Health Disparities in a Time of Retrenchment (1968 – 2018, 12 Geo. J. L. & Mod. Crit. Race Persp. _* (forthcoming 2020)).

[4] U.S. Gen. Accounting Office, Letter from John E. Dicken, Director of Health Care to the Honorable Ron Wyden of the United States Senate regarding I*nfection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic* (May 20, 2020).

Rachel M. Werner, MD, PhD and Courtney Harold Van Houtven, PhD, In The Time Of COVID-19, We Should Move High-Intensity Postacute Care Home, HEALTH AFF. BLOG (May, 4 2020), https://www.healthaffairs.org/do/10.1377/hblog20200422.924995/full/.

[6] Paula Chatterjee, MD, MPH, Allison K. Hoffman, JD, and Rachel M. Werner, MD, PhD, Shifting the Burden? Consequences of Postacute Care Payment Reform On Informal Caregivers, HEALTH AFF. BLOG (September 9, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190828.894278/full/.

infected, providers are not available because of concerns for their own health or their family member's health, or they are needed to care for COVID patients or other emergencies.

The need to reform health care regulations and policies of hospital and physician practices is highlighted by the following true story about a Medicare beneficiary of color. The elderly man had several chronic conditions and had been losing weight. He was so weak that he could not walk. His health condition had deteriorated over a few months such that the family decided to call an ambulance and transport him to the hospital. He was admitted to Piedmont Hospital in Atlanta, Georgia. The hospital ran many tests and the COVID-19 test came back negative. Once the patient was stable, the physicians at JenCare Senior Medical Center in Atlanta recommended to the family that their family member go to a rehabilitation hospital since he would not be able to care for himself and he needed rehabilitation services to gain some of the strength that he lost. The family was concerned that their family member would be at risk for contracting COVID-19. They were also concerned that they would not be able to visit the family member. Thus, it was decided and agreed that the patient needed and would receive 24 hour care at home. Unfortunately, there was no coordination of care with the family and the discharge was problematic.

The patient was discharged to the family without notice that the patient-family member was coming home. Neither the hospital nor the physician practice met with the family to advise them what care the patient needed or to train them to provide the care. There was no discussion about a follow-up visit. No durable medical equipment was provided to the family. No home health care provider came to the family's house the day the patient was discharged. The patient who was unstable walking, fell trying to go to the restroom. The patient also became reticent to eat and get out of bed after the fall. The family had a critical choice the next day, go back to the emergency room and get readmitted to Piedmont Hospital or continue working with the practice to see if the 24-7 home care would be provided. While the patient went to his JenCare physician the next day, no home health provider came to the house for two days. The only explanation provided by the JenCare physician for the failure to provide the 24-7 care was to state that their home health coordinator was out.

This care not only fell below the standard of care required, but it continues to stress the family. Fortunately, the family was able to call on several other family members to help provide some of the custodial care. But this is not how our health care system should work.

Solution: Continue to Incentivize Quality Care in Post-acute Settings & Recognize Potential Gaps

Providers need to be incentivized to provide appropriate care to patients. Regulatory incentives should include reimbursement and compliance mechanisms. Medicare already limits hospital reimbursement for patients that return to the hospital within a certain amount of days from discharge through the Hospital Readmissions Reduction Program. Medicare also includes an incentive for physicians to better manage the care provided to patients post discharge from the hospital through the Merit Based Incentives Payment System. However, the reimbursement incentives do not sufficiently protect patients if they choose not to go back to the hospital, which is a predicate to triggering the reimbursement penalties for health care providers. COVID-19 highlights a gap in the effectiveness of reimbursement focused quality incentive structures and highlights the need for a multi-pronged approach to facilitate a patient's receipt of quality care.

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