Illinois Health and Hospital Association

November 29, 2019

The Honorable Danny Davis
U.S. House of Representatives
Co-chair, Rural and Underserved
Communities Health Task Force
2159 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Brad Wenstrup
Co-chair, Rural and Underserved
Communities Health Task Force
2419 Rayburn House
Office Building
Washington, D.C. 20515

The Honorable Terri Sewell
Co-chair, Rural and Underserved
Communities Health Task Force
2201 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Jodey Arrington
Co-chair, Rural and Underserved
Communities Health Task Force
1029 Longworth House
Office Building
Washington, D.C. 20515

RE: Committee on Ways and Means Rural and Underserved Communities Health Task Force's Request for Information Regarding Priority Topics Affecting Health Status and Outcomes

Dear Co-chairs Davis, Sewell, Wenstrup and Arrington:

On behalf of the Illinois Health and Hospital Association's (IHA) more than 200 hospital and nearly 50 health system members, IHA is pleased to respond to your request for information on priority topics affecting health status and outcomes in rural and underserved communities. We appreciate the Committee's commitment to advancing legislation to ensure all individuals have access to the care they need, no matter where they live.

Specifically, IHA appreciates the opportunity to provide input regarding the Task Force's work to discuss the delivery and financing of healthcare and related social determinants in underserved areas and to identify strategies to address the challenges that contribute to health inequities.

Many of IHA's rural and urban hospitals know firsthand the challenges of maintaining access to health services in vulnerable communities. Lack of adequate reimbursement, shifts in healthcare delivery, workforce shortages, aging infrastructure and access to capital are among the numerous and complex factors that make it difficult to ensure access to services, especially those with higher costs. Currently, 42 percent of Illinois hospitals are operating on negative or extremely thin margins, and since 2005, 161 rural hospitals nationwide have closed, including 88 during just the past five years.

IHA urges Congress to take immediate action to address the urgent challenges affecting hospitals struggling to keep doors open and maintain and/or expand services to vulnerable populations. **IHA's recommendations for action focus on two areas: updating existing federal policies and programs and investing new resources in vulnerable communities.**

Specific and immediate actions Congress should take include addressing persistent underpayment by the Medicare and Medicaid programs, reversing recent cuts to hospitals (e.g., Medicare sequestration, site-neutral payment cuts, and 340B drug pricing program cuts), updating special payment adjustments and programs which have not kept pace with shifts in care delivery, providing new investment in underserved areas, and creating flexible payment and care delivery models that prioritize maintaining access over immediate programmatic savings.

Updating Federal Policies and Programs. Healthcare delivery has evolved in recent years to respond to two major changes: the shift in service provision from the inpatient to the outpatient setting; and the transformation of the healthcare system toward value-based care. These changes are the result of multiple factors including clinical advancements, patient preferences, and increased focus on improving health outcomes and lowering cost. However, several payment methodologies have failed to keep pace with these changes. For example, special rural payment programs (e.g., the Medicare Dependent Hospital (MDH) and Low-Volume Adjustment (LVA) programs) seek to account for the strain Medicare underpayment has on hospitals with a higher percentage of Medicare patients and overall low patient volumes by providing an add-on payment for inpatient services. These important programs need to be updated to include an outpatient adjustment.

At the same time, federal reimbursement cuts to hospitals and health systems strain a reimbursement system that already fails to cover the cost of providing care, preventing staff and financial resources from being directed to new delivery and new, more effective treatment initiatives. In its March 2018 report to Congress, the Medicare Payment and Advisory Committee (MedPAC), found that rural hospitals (not including critical access hospitals (CAHs)), had a Medicare margin of -7.4 percent. The payment shortfall in urban underserved communities is also significant: almost 40 percent of patients treated at Illinois safety-net hospitals are covered by Medicaid (compared to 17.9 percent for all other hospitals), which reimburses Illinois hospitals 25 percent below the cost of providing care.[1,2]

New Investment and Flexibility. IHA strongly recommends that, in addition to improving Medicare and Medicaid reimbursement and updating existing federal policies and programs, Congress invest new resources in vulnerable communities. We appreciate recent action to improve access to Broadband in underserved areas, and IHA urges Congress to build on this positive investment by creating a wider range of payment and delivery model options for

[1] Illinois Department of Public Health Annual Hospital Questionnaire, 2014.
[2] https://www.team-iha.org/files/non-gated/advocacy/federal-advocacy-agenda.aspx

vulnerable communities that allow providers to target solutions to unique circumstances (e.g., a rural emergency medical center model). Congress should also ensure access to more flexible grants and low-interest loans than are currently available to healthcare providers, increase Medicare support for graduate medical education (GME), and increase funding for the National Health Service Corps (NHSC) to enable more practitioners to participate and serve in rural or disproportionate share hospitals.

It is also important to note that access to comprehensive health insurance coverage is a fundamental factor affecting health in rural and underserved communities. The Affordable Care Act (ACA) significantly increased access to comprehensive coverage in the U.S., and IHA opposes recent efforts to chip away at certain protections under the law, and filed an amicus brief in the case of Texas v. U.S. in support of the law.

Again, IHA appreciates the opportunity to provide input on the Task Force's important discussion to identify strategies that address the challenges contributing to health inequities in urban and rural underserved areas.

We thank you for your focus on this critical issue. Our detailed comments and suggestions are attached. For more information, please contact Sarah Macchiarola, Vice President of Federal Government Relations at (630) 276-5645 or smacchiarola@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO
Illinois Health and Hospital Association

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
DETAILED COMMENTS ON WAYS AND MEANS COMMITTEE RURAL AND UNDERSERVED HEALTH TASK FORCE'S RFI

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?

While numerous factors influence patient outcomes, the existence of a local access point (i.e. brick and mortar facility) that provides essential healthcare services, such as emergency and observation care, primary care and behavioral health services is among the most fundamental. In addition to providing essential services, such access points play a critical role in coordinating or providing additional health and wellness services, such as working with community partners to address social determinants of health, serving as both distance and originating sites for the provision of telehealth services and leading quality improvement efforts.

Yet, due to the high fixed costs of operating a hospital, persistent underpayment by the Medicare and Medicaid programs, recent reimbursement cuts (e.g., Medicare sequestration, site-neutral payment policies, 340B Program cuts), outdated federal programs, demographic shifts and lack of new investment in underserved communities, many rural and urban safety-net providers struggle to achieve a positive operating margin and ensure access to essential services.

To help ensure access and improve health outcomes in underserved communities, IHA urges Congress to take the following action:

- Increase Medicare and Medicaid reimbursement to cover the cost of providing care;
- End the blunt 2 percent Medicare sequestration cut to all hospitals and Critical Access Hospitals (CAHs);
- Strengthen the viability of outpatient services by establishing new support through an add-on adjustment or other payment improvement mechanisms;
- Pass the Physician Shortage Reduction Act (H.R. 1763);
- Pass the Opioid Workforce Act (H.R. 2439);
- Pass the Conrad State 30 and Physician Access Reauthorization Act (H.R. 2895);
- Pass the Social Determinants Accelerator Act (H.R. 4004); and
- Strengthen the National Health Service Corps (NHSC) to expand the number of healthcare professionals serving in rural and underserved hospital settings. IHA supports the Rural America Health Corps Act (H.R. 4899), and requests it be updated to allow certain rural prospective payment system hospitals (i.e. 50 or fewer beds) to participate and to require a report on why only 0.5 percent of NHSC participants currently serve in CAHs, and 3.5 percent in Rural Health Clinics.[3]

[3] https://www.everycrsreport.com/files/20180426_R44970_5c4b0e675754b859468f9b81c92f66d63d8add3c.pdf

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?

Illinois hospitals and health systems lead and participate in numerous initiatives and care delivery models that seek to provide essential health services and address social determinants of health. Examples include:

- University of Illinois (UI) Health (Chicago, IL): Through its Better Health through Housing (BHH) pilot program, UI Health has invested $500,000 and partnered with the Chicago-based Center for Housing and Health to move chronically homeless patients directly from the emergency department (ED) into safe, stable housing with intensive case management. BHH has provided housing interventions for referred patients who were frequent visitors to the emergency room, resulting in a 67 percent reduction in emergency department utilization and 57 percent decrease in inpatient stays among participants.[4]
- Several hospitals, including Carle Foundation Hospital, Advocate Aurora Health and Lurie Children's Hospital operate mobile clinics focusing on community needs (e.g., dentistry and health screenings). For example, Carle's mobile clinic was deployed at the beginning of the school year to help increase vaccination rates in Champaign, Illinois' Garden Hills Elementary school neighborhood. Garden Hills Elementary has the lowest vaccination rate in the area at around 90 percent. Carle deployed its mobile clinic to not only help improve that rate but also to offer chronic disease screenings and physicals.[5] As a Vaccines For Children-certified clinic, the mobile clinic can offer immunizations free-of-charge.
- Northwestern Memorial Hospital (NMH): To reduce hospital admissions of older patients after a visit to the ED, NMH created the Geriatric Emergency Department Innovations (GEDI) program, which placed geriatric nurse liaisons in the ED to look at the patient as a whole, covering everything from screening for delirium, elder abuse and fall risks, to understanding how the patient accesses groceries and medicine, and what kind of social support system they have.[6] According to a study published in the Journal of the American Geriatrics Society which analyzed the program between 2013 and 2015, the GEDI program (implemented at NWH and other sites) reduced unnecessary hospital admissions by as much as 33 percent.[7] [8]

[4] https://housingforhealth.org/bhh/
[5] https://www.news-gazette.com/news/carle-s-mobile-health-clinic-helping-champaign-schools-keep-immunization/article_47aa7389-51b0-595a-9b77-1d33ef320013.html
[6] https://magazine.nm.org/2018/05/08/transitioning-to-health/
[7] http://news.feinberg.northwestern.edu/2018/01/emergency-department-program-for-older-adults-cuts-hospitalizations-by-33-percent/
[8] https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.15235

IHA urges Congress to create new opportunities to support initiatives and care delivery models such as these that improve access to essential health services and address social determinants of health. Importantly, Congress must also protect existing programs which are critical for rural and urban hospitals serving vulnerable patients and communities. These programs include the 340B Drug Pricing Program, the CAH, Medicare Dependent Hospital (MDH), Low-Volume Adjustment (LVA), Sole Community Hospital and Disproportionate Share Hospital programs.

3. What should the Committee consider with respect to patient volume adequacy in rural areas?

In recognition that hospitals in areas with low population density often lack scale to cover the high fixed costs of operating a hospital, Congress created several special rural payment programs. At the time of their creation, these programs primarily reflected the healthcare system's focus on acute, inpatient care. To be sure, inpatient support is still critical for hospitals with low patient volume; however, IHA also urges Congress to consider strengthening the viability of outpatient and other types of services.

Special payment programs created by Congress include the CAH program, which reimburses small, rural hospitals meeting certain criteria at 101 percent of costs (currently 99 percent due to Medicare sequestration); and the MDH, LVA and Sole Community Hospital programs, which provide certain hospitals with add-on payments. These programs need to be protected, and in the case of the MDH and LVA programs, updated, to include an add-on adjustment for outpatient services to account for increased use of outpatient hospital services.

IHA also urges Congress to create and fund additional flexible alternative payment and delivery models that would allow rural and urban hospitals to test new approaches, such as a rural emergency medical center model (see response to question 4).

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?

Healthcare is changing at a rapid pace and inadequate reimbursement and outdated payment programs strain the ability of some providers, namely, those serving vulnerable populations in rural and urban communities, to maintain access to essential services. To help address this, IHA urges Congress to create and fund new models and demonstration programs that enable hospitals to test and implement alternative ways of delivering and paying for care, while also enabling providers to target services to meet the unique needs of their communities.

One such example is a rural emergency medical center (REMC) model, which has been supported in bipartisan, bicameral legislation (H.R. 5678-115 and S. 1130-115), and was included in MedPAC's June 2018 Report to Congress.[9] IHA supports the creation of an REMC model to allow existing facilities to maintain emergency and outpatient services without having to provide inpatient services. This model responds to changing hospital utilization patterns and allows providers the flexibility to align additional outpatient and post-acute services with the unique needs of their communities.

(Note: Currently, numerous alternative payment and delivery models are being tested through the Center for Medicare and Medicaid Innovation (CMMI); however, these models are limited by the requirement to also achieve programmatic savings. IHA urges Congress to provide funding for additional models that focus on the needs of facilities in underserved communities, even if these models do not yield short-term savings.)

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

Persistent workforce shortages in rural and urban underserved communities create access challenges for patients and represent ongoing costs for hospitals working to recruit and retain professionals. One Illinois hospital CEO recently shared that it took three years to recruit a new physician to work in his rural hospital.

Several federal programs exist to help ameliorate these workforce deficits in underserved communities by providing incentives, such as loan repayment, to professionals. These programs are critical and IHA supports increased appropriations and flexibility to expand their reach. However, additional solutions also need to be developed, and IHA looks forward to partnering with policymakers and other stakeholders, such as the American Hospital Association, to ensure access to care for all individuals, no matter where they live.

In the meantime, actions Congress could immediately take to help address workforce shortages in rural and underserved areas include:

- Increase Medicare and Medicaid reimbursement to cover the cost of providing care;
- End the blunt 2 percent Medicare sequestration cut to all hospitals and CAHs;
- Update the MDH and LVA programs to include an outpatient add-on adjustment;
- Pass the Physician Shortage Reduction Act (H.R. 1763);
- Pass the Opioid Workforce Act (H.R. 2439);
- Pass the Conrad State 30 and Physician Access Reauthorization Act (H.R. 2895); and
- Strengthen the National Health Service Corps (NHSC) to expand the number of healthcare professionals participating as well as increase the number serving in rural and underserved hospital settings. IHA supports the Rural America Health Corps Act (H.R. 4899), and requests that it be updated to allow certain rural prospective payment

[9] http://medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf

system hospitals to participate and to require a report on why only 0.5 percent of NHSC participants currently serve in CAHs. And 3.5 percent in Rural Health Clinics[10]

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?

IHA urges Congress provide grant and other flexible funding opportunities to support existing programs with demonstrated, quantifiable success in targeting clinical improvements to rural and underserved communities. Two examples are: Project ECHO (Extension for Community Healthcare Outcomes) and Project ALTO (Alternatives to Opioids).

Project ECHO is a collaborative effort between specialist teams at academic medical centers and local clinicians in underserved areas that uses virtual technology to provide specialized knowledge and expand treatment capacity.[11] IHA and Southern Illinois University currently collaborate to provide direct, virtual training through Project ECHO to improve access to care for opioid use disorder in Illinois. Project ECHO has trained 147 newly waivered physicians across the state in the delivery of medication assisted treatment (MAT), including in MAT deserts in southern Illinois.

Project ALTO trains hospital emergency departments (EDs) to provide pain treatment alternatives to opioids. Since it began, Project ALTO has seen a 21 percent reduction in the opioid prescriptions prescribed in the ED and a 13 percent increase in opioid alternatives administered in ALTO-trained EDs (compared to a 2018 baseline).

Finally, IHA again urges Congress to assess the reimbursement provided by the Medicare and Medicaid programs. Healthcare providers facilitate access to high-quality services every day across the country to Medicare and Medicaid beneficiaries at negative margins. Medicare and Medicaid reimbursement rates do not cover the cost of care, let alone allow for providers and facilities to operate on positive margins. In its March 2018 report to Congress, MedPAC found that rural hospitals (not including CAHs) had a Medicare margin of -7.4 percent. The payment shortfall in urban underserved communities is also significant: almost 40 percent treated at Illinois safety-net hospitals are covered by Medicaid (compared to 17.9 percent for all other hospitals), which reimburses Illinois hospitals 25 percent below the cost of providing care.[12,13] Finally, IHA recognizes the challenge in addressing the current formula that determines the Federal Medical Assistance Percentage (FMAP) for each state; however, given that Illinois is 50th in the nation in federal Medicaid funding support per beneficiary, the impact on safety-net providers cannot be ignored. IHA calls on Congress to address the persistent reimbursement shortfall from public payers, including changing the flawed FMAP formula.

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[10] https://www.everycrsreport.com/files/20180426_R44970_5c4b0e675754b859468f9b81c92f66d63d8add3c.pdf
[11] https://echo.unm.edu/about-echo/ourstory
[12] Illinois Department of Public Health Annual Hospital Questionnaire, 2014.
[13] https://www.team-iha.org/files/non-gated/advocacy/federal-advocacy-agenda.aspx