AMERICA'S ESSENTIAL HOSPITALS

September 25, 2020

The Honorable Chuck Grassley
Chair
Committee on Finance
United States Senate
135 Hart Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
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The Honorable Lamar Alexander
Chair
Committee on Health, Education, Labor and Pensions
United States Senate
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The Honorable Patty Murray
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The Honorable Frank Pallone Jr.
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The Honorable Greg Walden
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The Honorable Richard Neal
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United States House of Representatives
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The Honorable Kevin Brady
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Dear Chair Grassley, Chair Alexander, Chair Pallone, Chair Neal, Ranking Member Wyden, Ranking Member Murray, Ranking Member Walden, and Ranking Member Brady:

Thank you for your support of hospitals and providers caring for patients and communities during the COVID-19 pandemic. We have seen communities across the country struggle during the pandemic; however, often those hardest hit have been communities of color. Minority communities have seen a disproportionate impact from the virus, stemming from deep-seated racial and ethnic disparities. As the leading champion for hospitals and health

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systems providing high-quality care for all, including the vulnerable, America's Essential Hospitals appreciates Congress' interest in mitigating disparities exacerbated by COVID-19.

The work essential hospitals perform each day is proof-positive that a stable health care safety net is integral to improving health equity. As such, America's Essential Hospitals urges Congress to include policies that bolster the health care safety net in legislation developed to help rectify the unconscionable health inequities experienced by racial and ethnic minorities and other vulnerable populations in this country.

Our more than 300 member hospitals and health systems are the cornerstones of the nation's health care safety net. Three-quarters of their patients are uninsured or covered by Medicaid or Medicare.[1] Racial and ethnic minorities comprised more than half of discharges in 2018.[2] Essential hospitals anchor communities across the country, from large urban areas to small rural regions. They are sources of lifesaving care, jobs, and vital public health services that improve collective social, economic, and environmental circumstances. In communities served by essential hospitals, 23.3 million people live below the federal poverty line, 9.7 million have limited access to nutritious food, and 360,000 experience homelessness.[3]

Our association and its members are motivated to confront these injustices at the national level. We work to advance health equity through public policies, promote the sharing of best practices, and offer relevant educational content to essential hospital staff and leadership. This commitment to promote equity of care and eliminate disparities for the underserved is driven by the distinct position of essential hospitals within the health care delivery system. Essential hospitals see first-hand the adverse health outcomes tied to systemic racism that burden low-income populations and communities of color. They uniquely respond to the complex clinical and social needs of their patients by developing and offering social support and investing in preventive care services.

Accordingly, America's Essential Hospitals advocates for meaningful policy solutions that will help our members execute their mission-driven, safety-net role, which in turn benefits the individuals and communities they serve. Further, our association is committed to addressing the root cause of the socioeconomic factors that influence the disparities in health prevalent in communities anchored by essential hospitals. We recently announced an initiative to combat structural racism as a threat to public health. This effort will culminate with the dissemination of actions essential hospitals can undertake to tackle the disparities in health and social injustices that afflict their service areas.

The inequities that affect patients treated by essential hospitals manifest as chronic medical conditions, traumatic injuries, substance use, and mental health disorders, among other profound challenges for marginalized communities. Consequently, these vulnerable populations have been disproportionately harmed during public health emergencies despite advances in population health over the past several decades.

COVID-19 once again brings these pervasive disparities to the forefront. Reports by public health authorities, researchers, and the media have revealed marked disparities in how COVID-

[1] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2018 Annual Member Characteristics Survey.* America's Essential Hospitals. May 2020. https://essentialdata.info. Accessed July 10, 2020.
[2] Ibid
[3] Ibid

19 affects racial and ethnic minorities.[4] As I wrote in an April op-ed in *Modern Healthcare*: "[I]nequities in our social fabric and the broader health care system manifest in ways that put people of color in the path of COVID-19: Substandard housing and food insecurity thwart social distancing and exacerbate chronic conditions. Minorities who fill jobs in transportation and other critical infrastructure cannot stay home and, instead, are exposed to the virus. Those furloughed from hospitality and other 'nonessential' positions lose paychecks and insurance coverage and the health care access these bring."[5]

In addition to providing high-quality care, essential hospitals work to mitigate disparities to improve health outcomes and meet the social needs of their communities, especially in times of crisis. An essential hospital in Vermont works with local agencies and housing organizations to provide temporary housing and wraparound case management to patients discharged from the hospital who are in need of a place to stay. Another essential hospital in Minnesota works with Feeding America's Second Harvest Heartland food bank and other community partners to stock and distribute bags of nutritious groceries to patients and families in need of food assistance. Additionally, a partnership between an essential hospital in Pennsylvania and a local employment services organization provides job and training opportunities in the health care field, cultivating career opportunities, financial stability, and personal fulfillment.

Many essential hospitals and their partners are adapting existing programs to address social determinants of health (SDOH) to tackle the unique challenges presented by COVID-19, especially among homeless populations. An essential hospital in California works with partners to house homeless individuals in local hotels, and an essential hospital in Indiana participates in a cross-sector partnership to open an emergency isolation quarantine facility for all individuals experiencing homelessness who have tested positive, or are presumed positive, for COVID-19.[6]

As the COVID-19 public health emergency continues, essential hospitals serving these vulnerable populations are in an increasingly precarious position of responding to a pandemic with limited resources. Our members operate on margins one-third that of other hospitals.[7] Despite their financial constraints, they remain committed to their mission-driven, safety-net role through the current public health emergency and beyond.

To effectively fulfill this role and help eliminate the unconscionable disparities experienced by minority and marginalized populations, essential hospitals rely on the federal government to offer support and resources to sustain the health care safety net, especially during the current public health emergency. Congress should promote essential hospitals working to improve health equity by making sure policies:

- support robust data collection on patient demographic information and SDOH;
- ensure sustained and dependable federal funding and support for the health care safety net; and
- recognize the safety-net mission in quality and outcomes measures.

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[4] Roseman D. Essential Hospitals: COVID-19 Status. Essential Hospitals Institute. May 2020. https://essentialhospitals.org/wp-content/uploads/2020/05/AEH-COVID-19-Status-Brief-May-2020.pdf. Accessed July 10, 2020.

[5] Siegel B. A legacy of health disparities laid bare by COVID-19. *Modern Healthcare*. April 20, 2020. https://www.modernhealthcare.com/opinion-editorial/legacy-health-disparities-laid-bare-covid-19. Accessed June 22, 2020.

[6] Roseman D. Essential Hospitals: COVID-19 Status. Essential Hospitals Institute. May 2020. https://essentialhospitals.org/wp-content/uploads/2020/05/AEH-COVID-19-Status-Brief-May-2020.pdf. Accessed July 10, 2020.

[7] Clark D, Roberson B, Ramiah K. *Essential Data: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2018 Annual Member Characteristics Survey.* America's Essential Hospitals. May 2020. https://essentialdata.info. Accessed July 10, 2020.

1. Support Robust Data Collection on Patient Demographic Data and SDOH

America's Essential Hospitals supports gathering accurate, standardized information on patient demographic data. Clear and accurate data is critical when seeking to understand the challenges patients face and identifying existing disparities. The unconscionable rates of COVID-19 infections and deaths among Black, Latino, American Indian, and Alaska Native people and other minorities have emphasized the need for collection and analysis of data by race, ethnicity, and preferred spoken and written language of patients.

In 2011, the association partnered with other industry leaders in the National Call to Action to Eliminate Health Care Disparities, which promotes the culturally appropriate collection of patient race, ethnicity, and language (REL) information. We believe the collection of REL data supports hospitals' efforts to identify preferences and needs and to tailor care plans to specific patient characteristics. For example, collecting preferred language helps identify appropriate interpreter services, as necessary. The ability to monitor and stratify data also helps front-line staff identify needs and standardize efforts across hospitals.

As an important first step, the Paycheck Protection Program and Health Care Enhancement Act required the federal government to collect, analyze, and report morbidity, mortality, and other data related to the effects of COVID-19 on racial and ethnic minority populations. While this effort seeks to deepen our understanding of health disparities and their root causes, it is clear that more can and should be done to ensure all patients have equitable access to high-quality care. Lawmakers should build on their previous work by earmarking funds to enhance and expand these data collection and dissemination efforts and require the administration to use this information to target COVID-19 response efforts in underserved populations.

America's Essential Hospitals also supports efforts to improve the collection of SDOH information to better understand how these factors impact outcomes; this work is important in identifying the needs of our nation's most vulnerable patients. We support a consensus-building approach to determine relevant social factors and how to capture them in a standardized, culturally sensitive way. However, there are challenges to collecting SDOH data, including the sensitive nature of these conversations, a lack of alignment across screening tools, and a need to link data from medical and nonmedical sources (i.e., community services). Essential Hospitals Institute—the research, education, dissemination, and leadership development arm of America's Essential Hospitals—has produced reports on screening for SDOH that help front-line health care providers identify the needs of their patients and mitigate disparities.

Since 2015, providers have been able to use Z codes—a subset of ICD-10 codes—to capture social determinant information for Medicare fee-for-service (FFS) beneficiaries. An analysis from the Centers for Medicare & Medicaid Services (CMS) found that less than 2 percent of Medicare FFS beneficiaries in 2017 had a Z code associated with a claim.[8] Limited documentation of social determinant data hinders our capacity to understand and adequately address social barriers to positive health outcomes. By encouraging the collection of this data in a standardized manner, CMS can help ensure essential hospitals have the resources necessary to treat the adverse health outcomes caused by social barriers to care. For example, in its proposed Inpatient Prospective Payment System rule for FY 2020, CMS recommended changing the severity level designation of the ICD-10 code for homelessness (Z59) from a noncomorbid condition to a comorbid condition. CMS cited data suggesting that when the Z59 diagnosis code is reported as a secondary

[8] Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2017. CMS Office of Minority Health. January 2020. https://www.cms.gov/files/document/cms-omh-january2020-zcode-data-highlightpdf.pdf. Accessed July 15, 2020.

diagnosis, the resources involved in caring for the patient justify increasing the severity level. Although CMS chose not to finalize this policy, the association encourages Congress to engage with CMS on making these types of coding and payment adjustments available through existing mechanisms.

When equipped with proper data, essential hospitals can innovate and collaborate with community partners to mitigate health disparities, improve outcomes, and reduce health care costs. For example, 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. In fact, a recent financial investment from Pennsylvania in this collaborative will support HEZ efforts on employment and housing protections, activities that can help mitigate barriers to care and reduce disparities.[9]

Similarly, the Chicago Area Patient-Centered Outcomes Research Network (CAPriCORN) 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, which was born of the Patient-Centered Outcomes Research Institute, is designed to overcome barriers to care resulting from fragmentation and increase resources to develop, test, and implement strategies to improve care for diverse populations and reduce health disparities.

Congress should work with the administration to provide additional resources for data collection, leveraging existing best practices to ensure thorough and meaningful data. This is a critical step in understanding existing health disparities.

2. Ensure Sustained and Dependable Federal Funding and Support for the Health Care Safety Net

A stable health care safety net is critical to supporting underserved communities, including many racial and ethnic minorities. Essential hospitals heavily rely on a patchwork of federal financial resources to conduct many of their patient-level SDOH initiatives. For example, essential hospitals across the country are initiating programs to help address maternal morbidity and mortality, a pressing public health issue that disproportionately impacts women of color. A program at an essential hospital in Delaware connects pregnant women and new parents to health care, social services, education, and home health visiting programs. In coordination with community partners, the hospital organized an educational community baby shower. Participants were eligible for donated gifts and prizes, such as baby clothes and breast pumps. Another essential hospital in Michigan launched the Women-Inspired Neighborhood (WIN) Network. The WIN Network is a pilot program for enhanced group prenatal care with community health workers and certified nurse midwives. These two examples, along with many other successful policies and programs in place at essential hospitals, would not be sustainable without access to adequate federal resources.

[9] George, J. State invests $4 million in North Philadelphia's Health Enterprise Zone. *Philadelphia Business Journal.* October 18, 2019. https://www.bizjournals.com/philadelphia/news/2019/10/18/state-invests-4-million-in-north-philadelphia-s.html. Accessed August 21, 2020.

Congress has long recognized the unique financial challenges experienced by mission-driven hospitals that treat high numbers of Medicaid and low-income patients. Medicaid supplemental payments, such as Medicaid disproportionate share hospital (DSH) funding, help ensure the financial stability of essential hospitals and provide funding crucial to achieving their safety-net missions. Any instability in the Medicaid program—for example, through reductions in DSH payments and limits on how a state may finance its share of Medicaid as proposed in the recently withdrawn Medicaid Fiscal Accountability Rule—will hamper hospital efforts to provide support and services necessary to help community members lead healthy, productive lives.

Similarly, Congress established the 340B Drug Pricing Program to enable covered entities, including essential hospitals, "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services."[10] The program gives essential hospitals the financial flexibility to tailor services and programs to their community's unique challenges at nearly no cost to taxpayers. For example, an essential hospital in Iowa uses 340B savings to offset the costs of outpatient medications for low-income residents in the state's public health insurance program, which does not cover these drugs. Another essential hospital in Texas relied on 340B savings to operate school-based health centers in multiple low-income communities. Without the savings generated by the 340B program, many essential hospitals might not be able to offer additional comprehensive services that help vulnerable populations access care.

Medicare payment policies also influence how essential hospitals can reach vulnerable communities and expand access to life-saving care. Enacting site-neutral payment policies for many hospital outpatient facilities, for example, would render clinic expansion in underserved communities financially unsustainable, leaving vulnerable people with even less access to care.

Systematic erosion of the health care safety net would hit hardest the vulnerable patients served by essential hospitals. Congress should act to preserve the safety-net supports that essential hospitals rely on to fulfill their mission of care for all. Specifically, Congress should consider developing permanent incentives, potentially through the Medicaid program, for initiatives to eliminate health disparities. A dedicated stream of support would help essential hospitals develop and maintain SDOH programming and policies that could transcend financial threats experienced by the hospital, ultimately benefiting the communities they serve.

3. Recognize the Safety-Net Mission in Quality and Outcomes Measures

Quality and outcomes measures tied to financial payments should be risk-adjusted to accurately reflect the high-quality care provided by essential hospitals. The current system financially penalizes essential hospitals that treat populations with significant social barriers to care without factoring in these barriers when assessing performance. Simply put, this creates a vicious cycle that reduces the already scarce resources of these hospitals have to treat vulnerable populations.

America's Essential Hospitals supports the creation and implementation of measures that lead to quality improvement. As an example, there is a dearth of quality measures to address maternal morbidity, a health equity issue in which Congress expressed significant concern and continues to address in a bipartisan manner.

The Measure Applications Partnership (MAP) of the National Quality Forum (NQF) recently reviewed a structural metric put forth by CMS to measure severe maternal morbidity in the

[10] *340B Drug Pricing Program*. Health Resources and Services Administration. https://www.hrsa.gov/opa/index.html. Accessed July 13, 2020.

inpatient hospital setting. This metric would ask hospitals to attest to participation in a statewide or national perinatal quality improvement collaborative program, or both, aimed at improving maternal outcomes. As a member of the MAP, the association is working with the NQF to modify this measure to ensure it is accurate and can be meaningfully used by stakeholders.

Further, when a conceptual and empirical basis exists, quality measures should account for the socioeconomic and sociodemographic complexities of vulnerable populations to ensure the quality of care is reflected, rather than factors outside of hospitals' control. Outcomes measures, especially those for readmissions, do not accurately reflect hospitals' performance if they do not account for sociodemographic factors that can complicate care. For example, patients who do not have a reliable support structure at discharge are more likely to be readmitted to a hospital or other institutional setting. Measures must be properly constructed and not lead to unintended consequences, such as capturing misleading and incomplete information.

Medicare's Overall Hospital Quality Star Rating Program presents similar challenges. Star ratings were developed to summarize Hospital Compare quality measures in a consumer-friendly way, yet they increasingly are used as a measure of overall hospital quality. America's Essential Hospitals supports sharing meaningful hospital quality information with patients. However, the association believes 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 issues with CMS and remains concerned about the continued publication of star ratings using flawed methodology, including the lack of consideration for severe socioeconomic challenges faced by patients served by essential hospitals. Congressional lawmakers hold similar concerns and we have supported bipartisan efforts that urged CMS to include SDOH and socioeconomic status in hospital star ratings.

Moreover, 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, found 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.[11,12]

The results of a recent *JAMA* study suggest that "given the persistent disparities in health care–associated infection rates, value-based incentive programs currently function as a disproportionate financial penalty system for safety-net hospitals that provide no measurable population-level benefits."[13] Essential hospitals are punished financially for treating disadvantaged populations, ultimately hampering necessary resources to care for patients.

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[11] Clark D, Roberson B. Patient Experience and HCAHPS at Essential Hospitals. Essential Hospitals Institute. October 2019. https://essentialhospitals.org/wp-content/uploads/2019/10/HCAHPS-research-brief-October-2019.pdf. Accessed September 3, 2020.

[12] For additional peer-reviewed studies on socioeconomic status and risk adjustment, please visit https://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/.

[13] Hsu HE, Wang R, Broadwell C, et al. Association Between Federal Value-Based Incentive Programs and Health Care–Associated Infection Rates in Safety-Net and Non–Safety-Net Hospitals. *JAMA Netw Open*. 2020;3(7):e209700. Accessed July 15, 2020.

The association encourages Congress to work with the administration to acknowledge and account for factors unrelated to the quality of care hospitals provide that impact performance on measures and ratings. Policymakers should structure incentives in a way that accounts for factors affecting the measurement of patient experience, promotes equity, and rewards continued improvement.

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Essential hospitals face the daily reality that the communities they serve are plagued by social and economic disparities rooted in systemic racism and inequities. The federal government has a meaningful role in addressing health disparities, part of which includes securing the stability of the health care safety net. As Congress continues to critically explore and evaluate work that eliminates health disparities and promotes equity, please use America's Essential Hospitals and our members as a resource.

Thank you for your attention to this timely public health and equity issue. The association looks forward to partnering with you to advance policies and practices that will help all patients have a fair shot at achieving health and wellness by accessing high-quality and affordable care. If you have questions, please contact Vice President of Legislative Affairs Carlos Jackson at 202-585-0112 or cjackson@essentialhospitals.org.

Sincerely,

Bruce Siegel, MD, MPH
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America's Essential Hospitals