AMERICA'S ESSENTIAL HOSPITALS

March 20, 2023

The Honorable Bernie Sanders
Chairman
Committee on Health, Education,
Labor, and Pensions
United States Senate
Washington, DC 20510

The Honorable Bill Cassidy
Ranking Member
Committee on Health, Education,
Labor, and Pensions
United States Senate
Washington, DC 20510

Dear Chairman Sanders and Ranking Member Cassidy:

Thank you for your leadership in finding bipartisan solutions to remedy our nation's health care workforce shortages.

America's Essential Hospitals represents public and nonprofit hospitals dedicated to providing high-quality care to all. They are mission-driven; they serve communities in which 15.8 million individuals live below the poverty line, account for nearly a third of the nation's level I trauma centers and 40 percent of burn care beds, and train nearly three times more physician residents than other U.S. teaching hospitals.[1] Our more than 300 members form the very fabric of the nation's health care safety net.

At the heart of essential hospitals and their mission is the health care workforce.

The United States faces a significant and pervasive workforce shortage, especially in underserved and traditionally marginalized communities. The pandemic has placed an enormous strain on essential hospital employees, as burnout is at an all-time high. Demand for care forces essential hospitals to compete for staff with more financially stable for-profit systems, making recruitment and retention critical concerns. Provider shortages have the potential not only to affect patient care, but also to stretch staff's mental health to the limits, exacerbating challenges to maintaining a healthy workforce at sufficient levels. An estimated additional 124,000 physicians will be needed by 2034, and an additional 1.1 million nurses are needed to prevent a future shortage.[2]

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[1] Clark D, Ramiah K, Taylor J, et al. *Essential Data 2022: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. essentialdata.info. Accessed March 17, 2023.
[2] Association of American Medical Colleges. Physician Supply and Demand — A 15-Year Outlook: Key Findings. June 2021. https://www.aamc.org/media/54686/download?attachment. Accessed March 17, 20203

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As lawmakers discuss how to address current and future workforce shortages, America's Essential Hospitals urges consideration of the following principles.

- Public policies must develop and sustain a diverse, inclusive, and cohesive health care workforce that will reflect the country's multicultural communities, address health disparities, and ensure quality and patient safety.
- More training and residency slots for allied health professionals, nurses, and physicians must be created and financially supported not only to address the current workforce shortage, but also to meet the changing demands of tomorrow's health care system. Additional slots should be targeted to meet the needs of underserved communities.
- Professional health care workers remain a vital aspect of our health care system and must receive adequate support and resources to maintain their wellbeing and reflect the value of their essential services.
- Essential hospitals must be reimbursed adequately to achieve their missions while offering salaries and benefits that enable recruitment and retention of staff in today's increasingly competitive market.
- The federal and state governments must provide flexible and sufficient resources to meet increased staffing needs during public health emergencies, natural disasters, and periods of civil unrest.
- Immigration policies should allow a clear and easy path for all foreign nationals with medical and clinical backgrounds who wish to work, train, or study in the United States. This is a critical way to help address the provider shortage gap and provide culturally appropriate care to diverse communities, especially during periods of increased staffing needs.

PRINCIPLE: Public policies must develop and sustain a diverse, inclusive, and cohesive health care workforce that will reflect the country's multicultural communities, address health disparities, and ensure quality and patient safety.

Essential hospitals are committed to training the next generation of health professionals and equipping them with the necessary skills to provide culturally and linguistically competent care. More than 80 percent of essential hospitals are teaching institutions, and on average, essential hospitals trained nearly three times as many physicians as other U.S. teaching hospitals. Our members also trained 32 percent more physicians beyond their federal funding cap than other U.S. teaching hospitals. Further, nearly one in 10 allied health professionals—such as medical technologists, occupational and physical therapists, radiographers, and speech language pathologists—trained in an acute-care facility received their training at a member hospital.[3]

By virtue of their mission to serve all patients regardless of social or economic circumstance, as well as their work to combat structural racism, essential hospitals are well-situated to promote health equity. Because of their own diverse workforce and experience treating diverse patients, essential hospitals are uniquely prepared to provide the culturally competent care their patients need. They incorporate cultural competency and implicit bias training in their residency programs, preparing the next general of the health care workforce who go on to practice in underserved communities.

[3] Clark D, Ramiah K, Taylor J, et al. *Essential Data 2022: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. essentialdata.info. Accessed March 17, 2023.

The composition, distribution, and training of the health care workforce influences health equity and outcomes. Black, Latino, and Native Americans are significantly underrepresented in the health care workforce. Challenges finding a health professional who shares a patient's race and ethnicity can negatively affect their experience and outcomes. In addition, the effects of the overall provider shortage in this country can be even greater for underserved populations, including people of color. Exacerbating the problem, providers serving Medicaid beneficiaries and the uninsured face high turnover rates and struggle to compete for staff with more financially stable systems serving less medically complex patients.

We urge lawmakers to invest in the health care pipeline and target programs to promote a diverse, culturally competent workforce. Specifically, we support federal authorization and appropriations for:

- Loan repayment programs to include more health workers, especially those who come from disadvantaged backgrounds.
- Perinatal and maternal health care workforce development and diversification, with additional resources for doulas.
- Mental health and substance use disorder workforce development, including practitioners focused on maternal mental health and substance use disorder.
- Antidiscrimination and bias training.
- Nursing education and modernization grants for underserved areas.
- The Nurse Corps.
- Health Professions Opportunities Grants demonstration programs providing education and training, including to justice-involved individuals, for health care careers.

PRINCIPLE: More training and residency slots for allied health professionals, nurses, and physicians must be created and financially supported not only to address the current workforce shortage, but also to meet the changing demands of tomorrow's health care system. Additional slots should be targeted to meet the needs of underserved communities.

We appreciate and applaud Congress' work to add 1,000 new Medicare-funded physician residency slots in the Consolidated Appropriations Act (CAA), 2021, phasing in 200 slots per year over five years. This was an important step, but more slots are still needed. We urge you to work with your colleagues to support the Resident Physician Shortage Reduction Act when it is reintroduced in the 118th Congress.

In allocating the 200 new residency slots for fiscal year (FY) 2023, the Centers for Medicare and Medicaid Services (CMS) prioritized hospitals with training programs in geographic areas demonstrating the greatest need for additional providers, as determined by Health Professional Shortage Areas (HPSAs), and further detailed the four categories of hospitals eligible for the new slots:

- Rural hospitals.
- Hospitals training over their Medicare cap.
- Hospitals in states with new residency programs or additional locations and branches of existing medical schools.
- Hospitals that serve geographic HPSAs.

America's Essential Hospitals strongly supports the agency's focus on promoting health equity, but we believe CMS' chosen methodology will fall short of achieving this goal. Through the

existing four eligibility criteria, CMS already accounts for hospitals located in a HPSA, so it is duplicative to prioritize applications based on HPSA scores alone. Moreover, HPSAs do not capture the full range of social determinants of health affecting the well-being of marginalized communities.

Because hospitals typically treat patients from large geographic areas that extend past their immediate vicinity, a hospital's location in a HPSA does not necessarily indicate the types of patients the hospital is treating, A hospital also can be outside of a HPSA but still treat patients living in multiple other nearby HPSAs, for which CMS would not account under its chosen methodology. In fact, the presence of a large health system with a vast network of various specialty providers serving patients in the hospital and its affiliated outpatient locations often results in the immediate geographic area not qualifying as a HPSA. Notwithstanding the absence of a HPSA designation, these hospitals still treat predominantly low-income and other underrepresented patients.

In addition to these shortcomings, prioritizing hospitals solely based on their HPSA score leaves out key indicators of a hospital's commitment and experience treating underrepresented populations, including whether a residency program's curriculum incorporates elements such as implicit bias training and an exploration of the effects of structural racism on the provision of health care and health outcomes.

Congress should direct CMS to prioritize instead applications from hospitals committed to serving marginalized populations, with a proven track record in training the health care workforce to treat these communities and provide culturally competent care. Beginning in FY 2024, CMS should target the slots to these hospitals—specifically, teaching hospitals that offer access to essential community services for low-income, uninsured, and vulnerable populations, such as the continuum of primary through quaternary care, including the provision of trauma care, public health services, mental health services, and substance abuse services.

Congress also should direct CMS not to use bed size, an arbitrary metric that does not reflect a hospitals' commitment to underrepresented populations, to rank hospitals within a priority grouping. Instead of focusing on bed size, the agency could give additional weight to hospitals that meet multiple eligibility criteria. For example, within a given HPSA score grouping, hospitals that meet three or four out of four eligibility criteria would receive precedence over hospitals that meet one out of four of the eligibility categories. Focusing on these criteria, instead of the number of beds, better captures a hospital's commitment to teaching underrepresented populations relative to other applicants and is consistent with the intent of the CAA, which explicitly listed these eligibility categories.

PRINCIPLE: Professional health care workers remain a vital aspect of our health care system and must receive adequate support and resources to maintain their wellbeing and reflect the value of their essential services.

Although the end of the COVID-19 public health emergency (PHE) is approaching, extreme burnout and other mental health effects will remain. In addition to growing and diversifying the health care workforce pipeline, Congress also must invest in retention and support for our existing workforce, including access to needed mental health services.

We urge lawmakers to appropriate funding for grants created by the Dr. Lorna Breen Health Care Provider Protection Act for programs to promote mental health, resiliency, and relevant mental and behavioral health training for health care students, residents, or professionals.

Additionally, violence and intimidation in health care settings have escalated at unprecedented rates in recent years, in part due to stresses from the COVID-19 pandemic. In 2018, health care workers accounted for 73 percent of all nonfatal workplace injuries and illnesses due to violence.[4] Incidence rates continue to grow, increasing from 10.4 per 10,000 full-time workers in 2018 to 15 in 2020.[5]

Many health care workers experience verbally aggressive patients and visitors.[6] Hospital staff, particularly nurses, are experiencing increased physical violence in the workplace.[7] More emergency physicians report assaults and increased anxiety due to emergency department violence.[8] Verbal abuse and violence not only create an unsafe work environment but also contribute to health care worker burnout, an important factor in the health care workforce shortage.[9] While most states have enhanced criminal penalties for violence against health care workers, an increasing number are driving adoption of workplace violence prevention programs as another response to this serious issue.

Last Congress, America's Essential Hospitals endorsed the Safety from Violence for Healthcare Employees (SAVE) Act (H.R. 7961), legislation in the House of Representatives that would protect caregivers from workplace violence. The legislation would provide legal penalties, similar to federal protections that exist for flight crews, for individuals who knowingly and intentionally assault or intimidate hospital employees. While Congress and the Department of Justice have addressed violence against airline workers, they have not done the same for the health care workforce. We urge you to work with your colleagues to take up and pass legislation to protect the health care workforce.

PRINCIPLE: Essential hospitals must be reimbursed adequately to achieve their missions while offering salaries and benefits that enable recruitment and retention of staff in today's increasingly competitive market.

Essential hospitals provide a disproportionate share of the nation's uncompensated care while operating on margins that are about 60 percent lower than other U.S. hospitals.[10] Three-quarters of essential hospitals' patients are uninsured or covered by Medicaid or Medicare, and

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[4] U.S. Bureau of Labor Statistics. Fact Sheet: Workplace Violence in Healthcare, 2018. April 2020. https://www.bls.gov/iif/factsheets/ workplace-violence-healthcare-2018.htm. Accessed March 17, 2023.
[5] U.S. Bureau Of Labor Statistics. Employer-Reported Workplace Injuries and Illnesses – 2021. November 9, 2022. https://www.bls.gov/news.release/pdf/osh.pdf. Accessed March 17, 2023.
[6] Hare R, Tyler ER, Tapia A, et al. 2022 Updated Results for the AHRQ Surveys on Patient Safety Culture (SOPS®) Workplace Safety Supplemental Item Set for Hospitals. *Agency for Healthcare Research and Quality*. November 2022. https://www.ahrq.gov/sites/default/files/wysiwyg/sops/surveys/hospital/2022-hsops-wps-study-report.pdf. Accessed November 28, 2022.
[7] Byon, HD, Sagherian K, Kim Y, et al. Nurses' Experience with Type II Workplace Violence and Underreporting during the COVID-19 Pandemic. *Workplace Health & Safety*. 2022;70(9):412–420. https://journals.sagepub.com/doi/full/10.1177/21650799211031233. Accessed November 22, 2022.
[8] American College of Emergency Physicians. Poll: ED Violence is on the Rise. August 2022. https://www.emergencyphysicians.org/article/er101/poll-ed-violence-is-on-the-rise. Accessed November 22, 2022.
[9] U.S. Surgeon General. Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce. 2022. https://www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf. Accessed November 22, 2022.
[10] Clark D, Ramiah K, Taylor J, et al. *Essential Data 2022: Our Hospitals, Our Patients—Results of America's Essential Hospitals 2020 Annual Member Characteristics Survey*. America's Essential Hospitals. September 2022. essentialdata.info. Accessed March 17, 2023.

more than 8 percent are eligible for both Medicaid and Medicare.[11] Just one in five inpatient discharges and one in four outpatient visits at essential hospitals are covered by commercial insurance.[12]

Essential hospitals continue expending significant resources to recruit and retain medical staff—a costly undertaking in the already competitive labor marketplace. Due to understaffing, essential hospitals are experiencing increased costs associated with hiring bonuses, retention bonuses, and higher salaries to recruit and retain front-line nurses, who are in short supply. Shortages of health care staff, particularly nurses, and the greater costs associated with hiring and retaining practitioners worsen the financial stress on our member hospitals.

These financial challenges leave essential hospitals to rely on a patchwork of financial support and resources—Medicare and Medicaid disproportionate share hospital (DSH) payments, the 340B Drug Pricing Program, grants, and state and local funding— to serve the communities and patients on whom they rely. As indicated above, essential hospitals, due to their payer mix, do not have the ability to offset below-cost reimbursement rates for Medicaid, and, in some instances, Medicare, with commercial revenue. This, coupled with essential hospitals' high uninsured and self-pay rates, puts immense pressure on budgetary stability and planning. For example, without DSH payments, the average essential hospital will be forced to operate on a negative margin.

This year, Medicaid DSH faces a cut of $8 billion, more than two-thirds of the federal share of the program, and illegal actions by the pharmaceutical manufacturers threaten 340B savings. Further, essential hospitals face constant downward pressure on Medicare payment rates through proposed payment reductions, including site-neutral policy changes. Even further, chronic and systematic underfunding of Medicaid hampers work to dismantle structural inequities and hire and retain the health care workforce at public and nonprofit institutions serving a safety net role.

We urge you to work with your colleagues in the Senate Finance Committee and elsewhere to ensure adequate reimbursement and support for providers serving a disproportionate share of the most at-risk and vulnerable Americans, including protecting Medicare DSH payments, defending the 340B Drug Pricing Program from pharmaceutical manufacturers' illegal actions to restrict access to contract pharmacies, and supporting public health services, preparedness and infrastructure by reauthorizing the Hill-Burton program and appropriating adequate funding.

BENEFIT OF ESSENTIAL HOSPITAL DESIGNATION

Further, despite the integral role that hospitals serving as a safety net play in their communities and nationwide, there is no federal definition identifying them. We urge lawmakers to create a statutory definition for essential hospitals.

In the past, Congress has acted multiple times to identify hospitals with unique characteristics or those serving specific populations or regions—for example, Prospective Payment System–Exempt Cancer Hospitals, sole community hospitals, Critical Access Hospitals, and most recently, Rural Emergency Hospitals. In each case, policymakers recognized the need to formally codify defining criteria and policy incentives to stabilize and protect these important

[11] Ibid.
[12] Ibid.

providers within the larger health care ecosystem. Today, essential hospitals lack similar—and necessary—benefits and protections.

An essential hospital designation would supply lawmakers with an effective tool to better tailor public policy initiatives, including supporting the workforce at institutions caring for underserved communities, and to stabilize the health care safety net with targeted funding. The defining features of essential hospitals—their mission and the patients and communities they serve—are best captured by these measures:

- Disproportionate patient percentage: captures a hospital's portion of Medicaid and low-income Medicare patients.
- Deemed disproportionate share hospital status: highlights a commitment to serving a high percentage of Medicaid and low-income patients and accounts for differences in Medicaid among states.
- Medicare uncompensated care payment factor: identifies the relative amount of uncompensated care provided and can help capture the costs of care delivered to uninsured individuals.

PRINCIPLE: The federal and state governments must provide flexible and sufficient resources to meet increased staffing needs during public health emergencies, natural disasters, and periods of civil unrest.

The role of essential hospitals is even more critical during times of crisis, which stretch far beyond pandemics and include the effect of severe weather events, such as fires, floods, earthquakes, and other natural disasters, to incidents of mass violence, to the ongoing opioid epidemic. Essential hospitals remain unwavering in their commitment to meet their mission regardless of the myriad financial, capacity, staffing, and societal challenges these unprecedented times present. They've stretched their financial resources and workforce to serve their communities during times of immense hardship.

We urge Congress to establish an emergency funding pathway to meet the essential workforce needs of hospitals and other providers during public health emergencies and authorize and appropriate at least $10 billion to fund this effort. These funds should be targeted to providers with the greatest financial need and those who see high levels of low-income and at-risk patients.

PRINCIPLE: Immigration policies should allow a clear and easy path for all foreign nationals with medical and clinical backgrounds who wish to work, train, or study in the United States. This is a critical way to help address the provider shortage gap and provide culturally appropriate care to diverse communities, especially during periods of increased staffing needs.

Beyond emergency funding streams to ensure staffing capacity during emergencies, it is critical that Congress invest in long-term workforce solutions. The health care workforce shortage is significant and pervasive and has been greatly exacerbated by the COVID-19 PHE and the economic challenges that accompany it.

Immigrant clinicians who participate in a variety of visa and guest worker programs make up an important sector of the health care workforce. These individuals are a critical resource for essential hospitals, particularly in rural and at-risk communities. Many foreign-born clinicians are trained in the United States and want to remain here to practice but struggle to do so

because of administrative backlog and complexity with H-1B and J-1 visas. It is important that Congress consider ways to expedite visas for immigrant nurses and physicians during public health emergencies.

Last Congress, America's Essential Hospitals supported the Healthcare Workforce Resilience Act (S. 1024), legislation which would recapture unused immigrant visas for nurses and physicians that Congress previously authorized and allocate those visas to help bolster the clinician workforce. We ask that you work with your colleagues to support similar legislation in the 118th Congress.

We also supported the Conrad State 30 and Physician Access Reauthorization Act (S.1810) to extend the authorization of the Conrad 30 program that allows foreign-born physicians to remain in the United States upon completing their residencies under the condition that they practice in a high-need area.

Again, we urge assistance for your colleagues in the Senate Judiciary Committee and beyond to support these efforts. Congress should review these and other initiatives to identify opportunities to expand access to foreign clinicians to mitigate critical staffing shortages.

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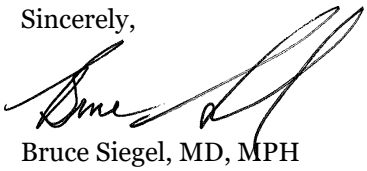
The health care workforce has experienced critical shortages for years, shortages that have been well documented and highlighted by members of Congress on both sides of the aisle. Those shortages, coupled with severe financial challenges faced by essential hospitals and other safety net providers, threaten our communities' access to critical health care services.

Thank you for the opportunity to share these workforce principles, and we look forward to working with you in the 118th Congress to help advance bipartisan solutions. If you have questions, please contact Jason Pray, vice president of legislative affairs, at 202-412-2491 or jpray@essentialhospitals.org.

Sincerely,



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