Anne's Testimony before the Hospital Transformation Review Committee

Wednesday, October 3rd, 2018, 10:30 AM

Illinois Department of Healthcare and Families Services (HFS)
HFS Clinton Building, 401 S. Clinton, 7th Floor, Chicago Office

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Introduction

My name is Anne Igoe and I am Director of the Hospital Division for SEIU Healthcare Illinois.

I would like to express my appreciation to you Chairman Harris and to all the members of this Committee for allowing me the opportunity to testify today.

SEIU Healthcare Illinois is a union of 90,000 healthcare, homecare, and childcare workers. SEIU members provide care and support services at hospitals across the city both many of which are private safety-net hospitals that provide critical services to low-income communities on Chicago's south and west sides and in Metro East St. Louis. We are also hear speaking on behalf of the 90,000 hospitals workers who live and work in the hospital industry in the Chicago land area.

The Hospital Transformation Review Committee convened here today is tasked with drafting rules for Phase 2 of the Hospital Transformation Program.

SEIU Healthcare believes that when drafting these rules that committee needs to take into consideration the responsibility of the state to adequately support these facilities and provide them additional funding and resources to expand services and address unmet health needs.

Many of our members also live in these low-income communities and depend on the safety-net hospitals which are often among the only

health service providers present. As has been testified many times over the past year and the past decades these communities are becoming healthcare deserts.

Any reduction in funding to these facilities in Phase 2 of the program could have catastrophic consequences including the closure of essential facilities in communities with few healthcare providers.

The Review Committee owes it to the workers and patients that depend on these facilities to slow down the Phase 2 rule making process and take as much time as necessary to get this right.

As stakeholders, workers and community organizations have a critical role to play in Phase 2 rule making beginning with making recommendations to the Committee.

In addition to requesting a deliberate and inclusive rule making process, we offer the following recommendations for Phase 2 of the Hospital Transformation Program:

I will state the four fundamental recommendations and core principals that we believe and strongly encourage this Committee to adopt. Then I will offer more specific analysis and context for each of our four policy recommendations.

Recommendation #1. We should limit eligibility for Phase 2 of the Transformation Program to Safety-Net and Critical Access Hospitals.

Recommendation #2. We should require eligible projects to preserve existing services and enhance the healthcare workforce.

We believe that Phase 2 of the Hospital Transformation Program must not directly or indirectly reduce access to care and must also invest in

the frontline hospital service workforce, such as C-N-As and housekeepers, that are still grossly unpaid and overworked.

Recommendation #3. Create a mechanism for non-industry stakeholders to participate in the project review and approval process.

We fundamentally believe that the Hospital Transformation Review Committee must provide an opportunity for public input by local community groups, hospital workers, and healthcare professionals.

Recommendation #4. Require eligible projects to target health inequities which are both reflective and predictive of unmet health needs.

SEIU Healthcare advises that the Hospital Assessment Program should focus on eradicating health inequities where they exist in medically underserved and economically isolated communities.

Chicago's African American and Latino neighborhoods which depend on safety-net facilities to provide essential health services suffer disproportionately from poverty due to divestment and segregation which creates and perpetuates health inequities.

Taken together these four recommendations will significantly improve the Hospital Assessment Program and achieve what was original mission: to provide, protect and expand quality healthcare to communities and populations who must need it.

But being mindful of the Committee's time I will offer more details, context and our reasoning for each of our four recommendations.

DETAILED TALKING POINTS FOR EACH POLICY RECOMMENDATION

Recommendation #1. Limit Eligibility for Phase 2of the Transformation Program to Safety-Net and Critical Access Hospitals.

- SEIU Healthcare contends that Phase 2 of the Hospital Transformation Program must continue to provide a lifeline to struggling safety-net hospitals.

- Urban safety-net hospitals and rural Critical Access Hospitals are embedded in communities rife with unmet health needs and health inequities and are best positioned to achieve Transformation Program objectives.

- For this reason, we strongly believe that the all $263 million in Hospital Transformation Program funding should go to safety-net and Critical Access facilities.

- The purpose of the Medicaid program is to provide healthcare to the poor and indigent. Safety-net and Critical Access providers shoulder a disproportionate share of this burden.

- The Illinois Medicaid Hospital Assessment raises and distributes $3.5 billion in Medicaid dollars to hospitals in largely in the form of static supplemental payments.

- Assessment-funded Medicaid supplemental payments are critical to safety-net facilities which have low or negative margins and little access to capital. As has been shared by providers despite

the safety nets preferred provider status the average payment is 120-200 days past service and this does not include those 20% of claims that are denied.

- Supplemental payments to safety-net hospitals, while modest in in the scheme of hospital finance, go a long way toward addressing unmet health needs. Payments to big system facilities, by contrast, subsidize profitable businesses that largely avoid and ignore poor communities where unmet health needs persist.

  Specifically the following:

Advocate: $6.5 billion cash and investments, could fund Transformation Pool for 25 years

Northwestern: $5.9 billion cash and investments, could fund Transformation Pool for 22 years

Ascension: $16.4 billion cash and investments, could fund Transformation Pool for 62 years

Yet when we see how various hospitals came out after the funding equation was applied we see both Advocate and Ascension as two of the largest winners in the assessment.

Currently only 140 Million of the transformation fund goes to safety nets and critical access hospital. we are proposing that the entire fund go to these entities to fund and expand services and address unmet health needs.

- The financial struggles of these facilities reflect inequities in the delivery system and are no fault of their own. Hospitals like Loretto and Roseland do not have the luxury of selecting which community identified health need they are going to invest in. Roseland continues to stabilize trauma patients in their ER despite

no promise of payment, Loretto continues to treat and provide rehabilitation to those who overdose in their ER. They do this because it is their mission. Yet large systems can build a profitable gym in the suburbs and write it off as their initiative to address obesity in DeKalb county.

- I am not saying the work these large systems are doing is not needed or important. But here there is no plausible reason for Illinois taxpayers to subsidize Advocate Health Care which has $6.5 billion in investments (including $1.9 billion in offshore investments) or Ascension Health (new parent of Presence Health) which earned a ridiculous $1.6 billion profit and has a $16.4 billion investment portfolio. Subsidizing big systems makes zero sense when they have ample resources with which to address unmet health needs in their services areas.

Recommendation #2. Require eligible projects to preserve existing services and enhance the healthcare workforce.

- SEIU Healthcare asserts that Phase 2 of the Hospital Transformation Program must not directly or indirectly reduce access to care. Specifically funds cannot be used to shut down or reduce currently utilized services.

- Phase 2 should extend Phase 1 static payments to safety-net facilities. Safety-net facilities depend on these static payments to sustain current operations, so any reduction would yield a corresponding reduction in access to care.

- Safety-net facilities require additional funding on top of current static payments to expand access to care in keeping with the goals of the Transformation Program.

- The Review Committee should categorically reject projects that reduce access to care by eliminating insufficiently profitable services (without the corresponding addition of services in area of greater demonstrated need) or converting inpatient acute care facilities to freestanding ERs or clinics.

- While the assessment bill makes it easier to convert inpatient acute care facilities to freestanding ERs, we believe it would be unwise and unjust to use Transformation Program dollars for such purposes. Transformation Program funds should expand access to care in communities where it is most needed, not facilitate hospital shutdowns and conversions in these very communities.

    - There has been some vague talk about over-bedding and serving certain communities more efficiently. Services should remain closest to where they are most needed. If anything, the concentration of facility locations geographically remote from underserved communities is a problem, not the fact that some hospitals have been able to remain operating in these communities.

    - For example, Hospital Planning Area A-01 which encompasses the affluent north side of Chicago is the most overbedded in Illinois with more than 1,000 excess hospitals beds (more than double the target number). There is not a

problem of over bedding in East St Louis or on the South and West Side of Chicago.

- Quality services require a strong and stable workforce supported by good wages and adequate staffing.

- Hospitals like Northwestern Memorial and University of Chicago Medical Center that pay workers well and engage in collective bargaining over wages and working conditions consistently rate as the best facilities in the Illinois.

Recently a study looking at hospital workers in the state of Illinois was shared with members of this committee:
The study looked at the problem of largely unregulated large systems operating in the State. The result is a workforce primarily made of women, specifically women of color of which the majority of support service positions 29,000 out of 33,000 make below 15 an hour and 22,000 make below 13. And I will remind the members of the committee that minimum wage in the city is 12 and in cook county is 11.

The reccommedations of this study were to increase to the wage of hospital workers to $15.00 an hour.

- For this reason, we contend that approved Phase 2 Transformation Program projects must include workforce benchmarks to toward a $15 minimum wage and support for increased staffing ratios.

Recommendation #3. Create a mechanism for non-industry stakeholders to participate in the project review and approval process.

- SEIU Healthcare asserts that the Hospital Transformation Review Committee must provide an opportunity for public input by local community groups, hospital workers, and healthcare professionals.

- The Committee should create a formal mechanism for stakeholder participation in both rulemaking and project approval and evaluation.

- Industry leaders and lobbyists must not disproportionately influence or control the project approval process and distribution of funds because industry actors do not represent community interests.

- Community stakeholders know best how to serve communities/what community health needs exist/what additional services are required.

- The Illinois Hospital Association and the big health systems that dominate its leadership have fundamentally different priorities than community stakeholders. Community stakeholders are concerned with unmet health needs and access to care; the IHA and big systems are more interested in maximizing profitability. This lack of commitment is reflected in the IHA's fight against the increase to the minimum wage, paid sick days, fair work week

scheduling, and any law or statute that would lead to safe staffing in facilities.

- Program funding should boost health equity, not subsidize hospital profits.

- Hospital workers also should have a role in shaping Phase 2 of the Hospital Transformation Program. Workers are critical stakeholders with different priorities than hospital leadership and can provide essential information and context regarding unmet health needs.

- Hospital workers and their representatives can speak to the importance of workforce development in creating an equitable delivery system.

- Many hospital service workers also live in medically underserved communities and rely on safety-net hospitals for critical health services.

- These workers can speak to both the unmet health needs in their communities as well as the difficulties making ends meet as low-wage workers with limited access to health insurance.

- The Review Committee must take whatever steps necessary to insure that workers and community members have a voice and seat at the table both in Phase 2 rulemaking and Transformation Program administration.

Recommendation #4. Require eligible projects to target health inequities which are both reflective and predictive of unmet health needs.

- Finally, SEIU Healthcare advises that the Hospital Assessment Program should focus on eradicating health inequities where they exist in medically underserved and economically isolated communities.
    - According to the Centers for Disease Control and Prevention (CDC), health inequities "negatively affect groups of people who have systematically experienced greater social or economic obstacles to health."

- Chicago's African American and Latino neighborhoods which depend on safety-net facilities to provide essential health services suffer disproportionately from poverty due to divestment and segregation which creates and perpetuates health inequities.

- Rural Illinoisans also experience significant health inequities compared to those in major metropolitan areas.

- Safety-net and Critical Access hospitals are the most appropriate facilities to address health inequities, but lack sufficient resources. The Hospital Transformation Program must provide resources they need to reduce inequities.

- This is not the same as simply using identified community health needs to authorize projects. Industry players like the IHA and big health systems may contend that any project that targets any identified unmet health need mentioned in a CHNA is potentially deserving of transformation funds.

- We contend that health disparities are the greatest unmet health needs and therefore most deserving of Transformation Program funds. As I testified earlier safety nets and critical access hospitals do not have the privilege of picking and choosing their unmet health need to focus on.

- For this reason, we are advising the Committee to make program eligibility contingent on addressing health inequities and/or underlying social determinants of health.

- Health inequities are differences in health that are closely linked to social and economic disadvantage.

    - According to the Centers for Disease Control and Prevention (CDC), health inequities "negatively affect groups of people who have systematically experienced greater social or economic obstacles to health."[i]

    - Health inequities result from social determinants of health including housing segregation and lack of investment.

- Illinoisans who live in poor urban and rural communities experience significant health inequities compared to those who in more affluent communities due in large part to negative social determinants of health.

- Chicago's African American and Latino neighborhoods which depend on safety-net facilities to provide essential health services

suffer disproportionately from poverty due to divestment and segregation which creates and perpetuates health inequities.

  - A recent study by Sinai Urban Health Institute found that inequities between Chicago's African American and White populations widened for most health status indicators examined between 1990 and 2010.[ii]

  - These inequities accounted for 2,454 excess African American deaths (deaths that would not have occurred if African Americans had the same mortality rate as Whites) in Chicago in 2010.[iii]

- Rural Illinoisans also experience significant health inequities compared to those in major metropolitan areas. Just as in urban communities of color, rural Illinoisans experience negative social determinants of health including poverty, unemployment, and limited access to health services.
  - Compared with urban areas, rural populations have lower median household incomes, a higher percentage of children living in poverty, fewer adults with postsecondary educations, more uninsured residents under age 65, and higher rates of mortality.[iv]

- Safety-net and Critical Access hospitals are the most appropriate facilities to address health inequities, but lack sufficient resources. The Hospital Transformation Program should provide the resources they need to reduce inequities.

- Interventions could include:

- Expansion of inpatient and outpatient services to target community specific health deficiencies and/or inequities.

- Expansion of primary and specialty care services. Including resources to recruit more competitive providers.

- Expansion/addition of behavioral health services.

- Addition of dental services.

Conclusion

SEIU Healthcare believes that these four recommendations should guide Hospital Transformation Program Phase 2 rulemaking.

The purpose of the program is to address unmet health needs, not enrich big health systems.

Safety-net and Critical Access facilities are poised to tackle persistent racial and economic health inequities but require additional support.

Phase 2 provides an opportunity to both shore up existing static funding and provide new dollars to expand access to care, invest in the hospital workforce, and reduce health inequities.

We strongly urge this **Committee** to also see these challenges of healthcare disparities in Illinois as an opportunity to address deep and pervasive issues of inequality.

This Committee has the ability to draft rules and guidelines and adopt a new course that serves EVERYONE – patients, hospital workers, and our communities.

We urge this Committee to seize this moment of opportunity for the good of Illinois.

Thank you.

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[i] "Social Determinants of Health – Definitions", Centers for Disease Control and Prevention, http://www.cdc.gov/socialdeterminants/Definitions.html.

[ii] Hunt, Bijou and Whitman, Steve, "Black: White Health Disparities in the United States and Chicago: 1990-2010," *Journal of Racial and Ethnic Health Disparities* (2014), doi: 10.1007/s40615-014-0052-0, https://link.springer.com/content/pdf/10.1007%2Fs40615-014-0052-0.pdf.

[iii] Ibid.

[iv] "Rural Health Snapshot 2017", North Carolina Rural Health Research Program (NC RHRP) at The University of North Carolina at Chapel Hill, May 2017 file:///C:/Users/zach.lutz/Downloads/Snapshot2017.pdf.