National Alliance of Safety-Net Hospitals

The Honorable Cheri Bustos
Co-Chair, The Congressional Social Determinants of Health Caucus
United States House of Representatives
Washington, DC 20515

The Honorable GK Butterfield
Co-Chair, The Congressional Social Determinants of Health Caucus
United States House of Representatives
Washington, DC 20515

The Honorable Tom Cole
Co-Chair, The Congressional Social Determinants of Health Caucus
United States House of Representatives
Washington, DC 20515

The Honorable Markwayne Mullin
Co-Chair, The Congressional Social Determinants of Health Caucus
United States House of Representatives
Washington, DC 20515

October 8, 2021

Dear Representatives Bustos, Cole, Butterfield, and Mullin:

Thank you for the recent opportunity to share the National Alliance of Safety-Net Hospitals' insights in response to the request for information issued by the Congressional Social Determinants of Health Caucus. NASH is grateful for the caucus's leadership on this vital issue and looks forward to working with you. We are writing to introduce you to our organization, to share our ideas about how to address social determinants of health, and to start a relationship working together in pursuit of our common objective of achieving true health equity.

NASH is an association of hospitals generally located in lower-income communities that care for especially large numbers of diverse, medically vulnerable, uninsured, underinsured, Medicare, and Medicaid patients. NASH advocates for adequate recognition and financing of community safety-net hospitals that serve America's neediest communities. These community safety-net hospitals differ from other hospitals in a number of important ways: they serve communities whose residents are older and poorer; they are more dependent on Medicare and Medicaid for revenue; they provide more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. Most operate on the thinnest of margins and have far fewer resources than private hospitals serving other, more affluent communities. NASH's role is to ensure that when federal officials make policy decisions they understand the implications of those decisions for these distinctive community safety-net hospitals. NASH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates. Private community safety-net hospitals can be found serving communities urban, rural, and suburban across the country. Many are teaching hospitals equipped to care for more medically challenging patients than the typical American community hospital.

Community safety-net hospitals have been working for years to address social determinants of health that lead to health inequities. In some cases these hospitals participate in broader efforts launched by the federal government, their state government, a local or county government, or by private, usually non-profit health and human services organizations in the communities they serve. In other instances they develop and implement their own initiatives because they see specific needs in their communities. Some of these efforts work better than others, some end when their funding ends, and some endure.

21351 Gentry Drive, Suite 210, Sterling, VA 20166
Phone: 703-444-0989
www.safetynetalliance.org

From experience community safety-net hospitals understand that the social determinants of health that have the greatest impact on the health of the residents of the kinds of communities they serve are – in no particular order – income/poverty, racial discrimination, inadequate education, immigration status, food insecurity, inadequate housing, exposure to violence, access to health care, and mental health challenges, which also encompasses substance use disorders. Homelessness is particularly a problem because it often encompasses many of these challenges.

Between the federal government, state governments, local and county governments, and community-based groups there already are many programs that seek to address one or more of the social determinants of health. One of the greatest challenges facing Congress, community safety-net hospitals, and others seeking to address health inequities is the high degree of fragmentation of these programs. Some, as noted, come from different levels of government, others from the private sector. Similarly, some address just one or two social determinants of health – say, access to care or food insecurity or literacy – while others attempt to be broader in scope. In many cases, the people who need these services most are unaware of their existence. Individually the services are not enough, and except in limited areas and for specific reasons they are barely coordinated with one another or not coordinated at all.

This, in NASH's view, is where Congress can have an impact on addressing the social determinants of health. Even the most capable among us find navigating this labyrinthine network of assistance programs daunting; it is even more challenging for those who cannot afford internet service, cannot read or speak English well, cannot find transportation to travel from one agency to another or someone to care for their children when they do, or are troubled too much by chronic, undertreated, or untreated medical problems to be effective advocates on their own behalf.

First, Congress can require greater coordination among federal assistance programs. Today there are a myriad of federal programs, or programs funded largely with federal money but administered by the states, that can help people who need help, including Medicaid, SNAP, WIC, LIHEAP, PACE, FQHCs, and others. Congress can identify gaps in this collection of services, create new ones to fill those gaps, and compel these programs to coordinate their efforts in a number of ways, including requiring them to use a single application for benefits that is automatically considered for every program to which it applies; standardizing or at least simplifying eligibility criteria for services; or requiring any agency that approves services for an individual either to share information about other benefits with that individual or share data about that individual with agencies that offer other federally supported services. For example, if an individual applies for and is approved by Medicaid, Medicaid could be required to share data about that person with SNAP, WIC, LIHEAP, and others. Streamlined applications, which are already in use in some states, may require addressing some HIPAA requirements to ensure patient and client confidentiality, but the benefits would be worth it: applicants might receive more than Medicaid benefits – benefits they truly need and that would support their overall health and well-being.

Second, Congress can require state Medicaid programs to make the coordination of services at the state, county, local, and community levels a covered Medicaid service for which the provider is reimbursed by Medicaid and for which the federal government will match state spending at the prevailing federal Medicaid matching rate. Today, many services are available to people in need but no one is responsible for connecting those in need to these services. The best way to address this fragmentation is to employ people in communities that face the greatest challenges whose sole job is to help connect people in need with services that are already available.

NASH knows of some safety-net hospitals that employ such coordinators. These coordinators are called in by medical staff when they encounter patients whose needs clearly go beyond the medical problem that brought them to the hospital in the first place. These hospitals are paying for these coordinators themselves but this is a luxury they may not be able to afford indefinitely and that some safety-net

hospitals will never be able to afford. In some places this is the job of social workers, but whether those social workers are employed by hospitals or community-based groups to help connect vulnerable people to services that would help address social determinants of health, the reach of those social workers ultimately is limited because in the current environment the fragmentation of services between agencies at all levels of government, and between many community-based groups, is so great. Providing resources to employ more professionals to help connect vulnerable people to the resources they need would help but is not enough. Congress can provide the additional help needed by building bridges between all of those various services and dedicate resources to help address the needs of the whole person.

NASH and its members have other ideas about how to address social determinants as well. We have experience in this area and would like work in partnership with the Social Determinants of Health Caucus to identify the health inequities we face every day and develop policies at the federal level that can help us address those inequities together. We would like to meet with you at your convenience to discuss these and other issues, and with this in mind, we will be in touch in the next week or so to see if we can schedule such a meeting.

We were pleased to learn of this caucus's creation and welcomed the opportunity to respond to your recent questionnaire and supplement that response with this letter. We also look forward to the prospect of working with you to address the social determinants of health that private, community safety-net hospitals have been working on for many, many years.

Sincerely,

Ellen Kugler, Esq.
Executive Director

About the National Alliance of Safety-Net Hospitals

The National Alliance of Safety-Net Hospitals advocates for adequate recognition and financing of private safety-net hospitals that serve America's neediest communities. These private safety-net hospitals differ from other hospitals in a number of key ways: they serve communities whose residents are older and poorer; they serve patients who are more dependent on Medicare and Medicaid for health care; they provide more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds to underwrite their costs. NASH's role is to ensure that when federal officials make policy decisions, they understand the implications of those decisions for the communities served by these distinctive private safety-net hospitals. NASH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.