National Alliance of Safety-Net Hospitals

James E. Matthews, Ph.D.
Executive Director
MedPAC
425 I Street NW, Suite 701
Washington DC 20001

October 21, 2021

Dear Dr. Matthews:

We are writing to continue the conversation MedPAC members initiated during their October 7 public meeting as part of the presentation on "Vulnerable Medicare beneficiaries' access to care," a subject Congress asked the agency to explore. In particular, the National Alliance of Safety-Net Hospitals is interested in the question of how best to define "safety-net hospital," a necessary precursor to any potential future action by Medicare to ensure that such hospitals have the resources they need both to continue serving their communities and, more to the point of the October 7 discussion, to improve access to care and health equity.

During that meeting MedPAC focused to a significant degree on whether the designation of "medically underserved area" serves as a reasonable proxy for communities in need. The conversation ended with the conclusion, as expressed in the presentation delivered during the meeting, that "Combined with other issues, suggests MUAs by themselves might not be useful in the Commission's work to identify vulnerable populations and support safety-net providers."

NASH agrees. The key question is how to define vulnerable populations and the safety-net hospitals that serve them. Over the course of NASH's more than two decades as an association we have periodically reconsidered the question of how best to identify safety-net hospitals and our definition has evolved over time.

One of the challenges in those deliberations has been the question of what data to use when considering the relative importance of hospitals to the communities they serve. During MedPAC's October 7 meeting the commissioners expressed frustration over data sources, observing that they do not seem granular enough for the objective at hand.

NASH, however, believes there now is data that is becoming granular enough to be a vital tool in a new way of looking for safety-net hospitals: *to look not at individual hospitals and consider what kinds of patients they serve but to focus on vulnerable communities and then to identify the hospitals that are caring for meaningful proportions of the residents of those communities*. This could lead to a more effective means of ensuring that true safety-net hospitals receive the supplemental resources they need to serve their communities, which appears to be a primary objective of MedPAC's current undertaking at the behest of Congress.

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The Centers for Disease Control and Prevention's (CDC) "PLACES" data is such a granular tool. As described by the CDC,

> PLACES, a collaboration between CDC, the Robert Wood Johnson Foundation, and the CDC Foundation, allows local health departments and jurisdictions regardless of population size and urban-rural status to better understand the burden and geographic distribution of health-related outcomes in their areas and assist them in planning public health interventions.
>
> PLACES provides model-based population-level analysis and community estimates to all counties, places (incorporated and census designated places), census tracts, and ZIP Code Tabulation Areas (ZCTAs) across the United States.

Through use of the kind of data available through PLACES – 13 measures of health outcomes, five measures of unhealthy behaviors, and nine forms of prevention, collected at the zip code level – policy-makers could identify geographic areas that can reasonably be considered vulnerable to access-to-care challenges and then, using Medicare fee-for-service data, identify hospitals that are the primary providers of care within those individual zip codes. This is truly granular data to which policy-makers have never before had access when formulating government health care policies.

Such an approach would have considerable potential for identifying safety-net hospitals based on which hospitals are serving communities in need in ways that can be objectively measured. Reaching such conclusions would then pave the way for new (or revised) policy measures that would help safety-net hospitals do this important work. They might even support these safety-net hospitals in doing more for these communities. Such an approach would lay a much-needed foundation for changes in the Medicare payment system that reduce barriers to access to care by making it more feasible for hospitals to serve vulnerable populations.

NASH does not want to be overly prescriptive in laying out how to do this because the entire subject needs more careful analysis and thought, but what would be needed are several decisions: how to identify communities for further analysis based on income and/or other factors; how to select the data to be used in evaluating access-to-care challenges in individual zip codes; how to identify which hospitals are serving meaningful numbers of residents of these communities (for example, using Medicare fee-for-service inpatient and outpatient data, which is used in PLACES, perhaps supplemented by Medicaid data, if MedPAC wishes); at what level to set individual hospitals' degree of service to a community to qualify it for designation as a safety-net hospital; and how to develop a new or revised payment mechanism that helps these more accurately identified safety-net hospitals with the work they are doing.

NASH recognizes that such an approach is not without its challenges, but the need for action is compelling. The current system, it is widely believed, is failing to serve too many people adequately, and the only way to ensure access to care in all places is to build incentives to provide such care into the Medicare (and the Medicaid) payment system. Despite this, NASH believes a fundamental shift is needed first, in how we define and identify true safety-net hospitals, and second, how we ensure that these hospitals receive the public resources they require to do the job we need them to do. The PLACES data, we believe, offers a new, unprecedented opportunity to do an important thing in a much better way and NASH believes we should seize this opportunity.

NASH would like to explore this issue further with MedPAC in the near future. We hope you will consider introducing at your next public meeting our idea about shifting the focus away from defining safety-net hospitals based on their payer mix and toward identifying which hospitals serve significant proportions of patients in medically vulnerable communities. We also would welcome an opportunity to meet with MedPAC commissioners or staff at your convenience to provide further details about the idea

we are advancing and to share with you some of the preliminary analysis we have performed based on this concept.

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.