ALLIANCE of SAFETY-NET HOSPITALS

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MedPAC
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Washington, DC 20001

Amol Navathe, M.D., Ph.D
Vice-Chair
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Dear Dr. Chernew and Dr. Navathe:

I am writing on behalf the Alliance of Safety-Net Hospitals (formerly the National Alliance of Safety-Net Hospitals), a group of community safety-net hospitals that serve economically disadvantaged and underserved communities, in response to the invitation from MedPAC commissioners during their December 8 meeting for stakeholders to submit comments and suggestions about the proposal for an alternative mechanism for supporting Medicare safety-net hospitals that was discussed during that meeting.

The Alliance of Safety-Net Hospitals (ASH) has long been a proponent of the federal government doing a better, more precise job of identifying safety-net hospitals and directing supplemental resources to them. In November of 2021 we met with MedPAC staff to discuss this very subject: that more could and should be done to direct supplemental payments to the true safety-net hospitals that are especially involved in caring for patients who live in vulnerable communities.

Our subject today is a continuation of that conversation of more than a year ago: the proposal that was presented at your December 8 meeting and concerns we have about specific aspects of that proposal that we would like to bring to your attention.

ASH believes the proposal as presented on December 8 could seriously jeopardize access to care for Medicare beneficiaries by cutting critical funding for many of the very safety-net hospitals to which many Medicare beneficiaries turn for care and possibly leading to their closure because of the Medicare DSH and Medicare uncompensated care payments they would lose. While we recognize MedPAC's belief that the commission's focus should be only on Medicare, as reflected in the statement from the December 8 presentation that says "Medicare indirectly subsidizes Medicaid," we believe that in the current environment, with so many states clearly shortchanging their Medicaid partners, MedPAC has little choice but to continue pursuing policies that reflect this need rather than attempt to ignore it. ASH hospitals, like many other community safety-net hospitals, serve especially large numbers of Medicaid patients in addition to meaningful numbers of Medicare patients and the simple reality is that if care for Medicaid and uninsured patients is not adequately reimbursed – through supplemental Medicaid payments and supplemental Medicare payments – then some of these safety-net hospitals will fold, as many have in recent years. This, in turn, will jeopardize access to care for entire communities – including for many Medicare

beneficiaries. In this sense, we believe Medicare's acknowledgment of the peril associated with Medicaid shortfalls should be viewed as Medicare's investment in access to care for Medicare beneficiaries. Without it, some Medicare beneficiaries would be at great risk of losing their access to care. We know you are well aware of this because at a public meeting earlier this year commissioners specifically talked about how hospitals that treat large numbers of Medicaid and low-income patients need help or they will not be there for Medicare patients.

We also are concerned that MedPAC's definition of safety-net hospital does not incorporate care for Medicaid recipients – specifically, how it proposes treating uncompensated care in its definition of "Medicare safety-net hospital." Many hospitals experience tens of millions of dollars worth of uncompensated care a year in the form of Medicaid shortfalls: the difference between what state Medicaid programs pay for services and what those services actually cost hospitals to deliver. For many hospitals in many states – especially Medicaid expansion states and states that do not have uncompensated care pools – Medicaid shortfalls dwarf their Medicare cost report S-10-defined uncompensated care (line 8 of the S-10). These shortfalls have the exact same impact on hospitals as S-10 uncompensated care, yet the formula MedPAC envisions for deciding what constitutes a safety-net hospital does not reflect this at all. ASH urges MedPAC to address this concern and recommends the use of line 31 of the S-10 cost report before it presents its Medicare safety-net hospital proposal to Congress.

ASH also is concerned that MedPAC proposes financing its new add-on payment for Medicare safety-net hospitals by "repurposing" current Medicare DSH and Medicare uncompensated care payments. This would be extremely damaging for many underfunded community safety-net hospitals that depend on Medicare DSH and Medicare uncompensated care payments. These, too, are hospitals that serve especially large numbers of Medicaid patients and have especially large Medicaid shortfalls; these same hospitals, however, serve significant numbers of Medicare patients as well. Reducing Medicare DSH and Medicare uncompensated care payments to these hospitals would be another unfair financial blow that, combined with so many of the other challenges such hospitals face, threatens to erode access to care.

We ask MedPAC to provide safeguards against such losses for community safety-net hospitals. These hospitals are almost always Medicaid- and Medicare-dependent, with relatively few commercially insured patients, and unlike their public counterparts they receive no local subsidies or tax dollars. States like Pennsylvania, for example, do not have any public hospitals, leaving the job of caring for low-income and medically vulnerable Medicare and other patients to community safety-net hospitals, some of which care for enormous numbers of low-income Medicare, Medicaid, and uninsured patients. Further, in states like California that do have county and other public hospitals, private community safety-net hospitals often can be found just a few miles down the road from them, serving a very comparable patient payer mix and doing so without the benefit of local subsidies or tax dollars from local governments. ASH believes these non-government hospitals – the Pennsylvania hospitals in a state with no public hospitals and the California hospitals working alongside county hospitals serving the same types of patients as those county hospitals and others like them across the country – are essential to access to care for medically vulnerable Medicare beneficiaries. We also agree with the assertion of some MedPAC commissioners that county hospitals may need to be protected amid the introduction of a new Medicare safety-net hospital concept amid an approach that will create new winners and losers but are hard-pressed to see a meaningful difference between county hospitals and the non-government hospitals described above. What is clear to see, however, is that we need all of these hospitals to care for their communities' Medicare beneficiaries.

At the December 8 meeting MedPAC invited stakeholders to submit suggestions for changes in the approach discussed during that meeting. With this in mind, ASH offers the following:

- If MedPAC wishes to pursue a formula for defining Medicare safety-net hospitals, please refine that formula to include Medicaid shortfalls in hospitals' uncompensated care total.
- Alternatively, MedPAC could adjust the formula to include hospitals' Medicaid share.
- In response to commissioners' request that stakeholders suggest provider types that should be held harmless from this proposal – the only type they discussed possibly holding harmless were county hospitals – ASH has developed a methodology for identifying such hospitals in a safety-net hospital proposal appended to this letter. ASH urges MedPAC to use this proposed methodology to identify hospitals that should be protected from the proposed redistribution of Medicare resources and held harmless from the loss of their Medicare DSH and Medicare uncompensated care payments.
- Make the safety-net hospital add-on payments a true new supplemental payment, over and above what hospitals currently receive, by proposing to retain current Medicare DSH and Medicare uncompensated care payments and urge Congress to finance the new add-on payments with new federal resources.

ASH appreciates MedPAC's interest in developing a better way of identifying true safety-net hospitals and ensuring that they receive the federal resources they need to preserve their continued ability to serve their patients and their communities. We value the start you have made and believe the suggestions we offer will help toward that end. We also welcome any questions you may have about our concerns and suggestions and look forward to future conversations with you about this subject. Finally, since ASH met with you last year we have spent a great deal of time, as noted above, considering how best to identify safety-net hospitals and how to structure supplemental payments to them, developing and modeling numerous approaches to both questions. Our innovative proposal for doing so is included as an appendix to this letter and we invite your consideration of using it as a guide to identifying the right hospitals for special consideration and your feedback in general in response to the broader approach we have crafted.

Sincerely,

Ellen J. Kugler, Esq.

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A Proposal to Advance Health Equity

November 2022

The Alliance of Safety-Net Hospitals proposes new supplemental Medicaid and Medicare payments to help safety-net hospitals advance health equity in the most challenging communities in the country.

Today's Health Inequity

A growing consensus has emerged among policy-makers and politicians, among patients and providers, and among serious academics and casual observers that Americans today do not enjoy equitable access to quality health care. One major factor driving this inequity is who is paying for care.

Those with commercial health insurance typically enjoy ready access to care and a wide choice of quality providers; those whose care is paid for by government have fewer choices and less access. Quality and access for those insured by Medicare varies greatly, depending on where people live. Medicare today pays adequately for some services but not for others and Medicare beneficiaries who live in communities where most people have commercial health insurance benefit from a broad health care infrastructure built to serve their commercially insured neighbors: a strong supply of providers working in modern, well-equipped hospitals, offices, and clinics.

The situation is quite different in communities characterized by large numbers or proportions of low-income, uninsured, and Medicaid-covered residents. With a few notable exceptions, most state Medicaid programs are notoriously poor payers. Over the years, doctors have increasingly chosen not to establish their practices in such places where they know they will be underpaid and some hospitals have even relocated to communities with a better-paying payer mix.

But the communities left behind still need care and are served by an ever-shrinking number of providers. The remaining hospitals often are starved for resources: their buildings are older, less functional, and more costly to maintain; they have limited access to the most modern medical technology and treatments; and they must resort to expending far too much of their limited resources not on improving their facilities but on providing to needy patients supplemental services for which no payment system will ever reimburse them and subsidizing the medical practices of doctors who otherwise would choose to practice elsewhere.

The cumulative impact of these and other factors on low-income communities is telling – and increasingly well-documented. It can be seen in the poor health status of the residents of these communities, where people are more likely to suffer from heart problems, hypertension, diabetes, asthma, and other medical problems – problems that those who reside in more affluent communities and have better insurance successfully avoid entirely or have diagnosed and treated earlier and more effectively because of their better access to timely, quality care. More often than not, the origins of the greater health challenges faced

by residents of low-income communities can be traced directly to the much-discussed social determinants of health that shape their lives and make their lifelong health problems, if not inevitable, then at least far more likely to arise and persist than those who live in communities of greater means with richer medical resources.

Numerous efforts are currently under way to address these social determinants of health, but without an adequate health care infrastructure to serve the people these efforts seek to help such initiatives can only have a limited impact.

What is needed to complement such programs is a much more precise way of identifying – and helping – the specific providers that today constitute the health care safety net by more clearly defining medically vulnerable communities and directing new, supplemental resources to those hospitals that demonstrably serve outsized proportions of the residents of those communities. The most deserving recipients of these resources need to be identified in a new and better way based on a careful calculation of the specific role they play serving those with the greatest needs in the communities with the greatest needs.

With these considerations in mind, the Alliance of Safety-Net Hospitals (ASH) proposes the following approach to identifying hospitals that play the greatest role in serving communities with the greatest health needs and providing them with new federal resources with which to carry out their vital work.

ASH's Medicare Proposal

ASH proposes two new supplemental Medicare payments: one payment through Medicare's inpatient prospective payment system and another through its outpatient prospective payment system. These new payments would be made based on where especially large numbers of vulnerable patients live to help support the operation of the hospitals that play the greatest role in serving those vulnerable communities.

As part of establishing these new payments ASH proposes creating and using three new terms:

- Health Opportunity Zone – a zip code with a Composite Health Disparity Score greater than one standard deviation above the mean Composite Health Disparity Score for the state in which individual hospitals are located based on disparity data derived from the CDC's PLACES dataset. (Note: While ASH uses PLACES data as the basis for identifying challenged communities, it welcomes discussion about other possible means of identifying those communities.)

- Composite Health Disparity Score – the simple average of a zip code's z-scores in relation to the entire state's scores for each PLACES measure used to identify especially challenged communities. (Note: this is the mathematical term "z-score," which is a numerical measurement that describes a value's relationship to the mean of a group of values, as distinguished from "z codes," a term used in medical claims coding to describe when the symptoms patients exhibit do not point to a specific disorder but still warrant treatment. Z codes frequently are used to describe circumstances that are affected or influenced by social determinants of health.)

- Critical Community Partner Hospital – a hospital that provides more than 10 percent of Medicare inpatient discharges or outpatient claims within a Health Opportunity Zone.

ASH's Proposed Supplemental Medicare Inpatient Payment

ASH's proposed supplemental Medicare inpatient payment seeks to help a very limited number of safety-net hospitals with the additional costs they incur identifying and coordinating community supports and services as part of the enhanced discharge planning needed to address the underlying contributing factors – the social determinants of health – of the poor health status of patients who reside in Health Opportunity Zones.

For services delivered to beneficiaries enrolled in traditional Medicare – that is, patients whose care is paid for under Medicare's inpatient prospective payment system – this inpatient payment would consist of a percentage add-on per claim for each Critical Community Partner Hospital discharge attributable to a Medicare patient who lives in a Health Opportunity Zone. This would be new federal money, not funding shifted from another health care program. ASH proposes that equivalent additional payments also would be paid for discharges of patients enrolled in Medicare Advantage plans through cost reporting reconciliation.

ASH's Proposed Supplemental Medicare Outpatient Payment

ASH also proposes a supplemental outpatient payment designed to encourage institutional providers to maintain and ideally to increase their presence in Health Opportunity Zones by giving them a financial incentive for doing so. This incentive would be a fixed dollar add-on for every Medicare outpatient prospective payment system claim filed by Critical Community Partner Hospitals for patients who are residents of Health Opportunity Zones. Like the proposed supplemental payment for inpatient discharges, this add-on payment would be paid for claims filed for outpatient services for patients enrolled in Medicare's fee-for-service program as an add-on per claim and for patients enrolled in Medicare Advantage plans through cost reporting reconciliation. In addition, off-campus provider-based locations of Critical Community Partner Hospitals that are located within a Health Opportunity Zone would be exempt from both outpatient prospective payment system site-neutral payment policies.

ASH's Medicaid Proposal

Medicaid programs vary greatly across states, so creating just one policy to address health equity in every scenario is a seemingly impossible challenge. ASH believes the single greatest thing the federal government can do to improve health equity under Medicaid is to give states the flexibility they need to address their own challenges by removing funding barriers that have historically disproportionately affected safety-net hospitals that provide care to vulnerable communities.

With this in mind, ASH proposes introducing a new state option to obtain federal matching funds for supplemental Medicaid payments to safety-net hospitals, with these new payments to come from new federal funds and not the reallocation of existing resources. The purpose of these new payments would be to help support the operation of the hospitals that play an especially important role in serving those vulnerable communities. These vulnerabilities can come from a community's small size, geographic isolation, or a reliance on relatively lower-paying Medicaid coverage to pay for care. To more narrowly define the hospitals on which vulnerable communities most depend, ASH proposes that only hospitals that meet the requirements for "Hospital-Deemed Disproportionate Share" described in section 1923(b) of the Social Security Act (hospitals that have a Medicaid utilization rate at least one standard deviation above the mean for hospitals in their state that receive Medicaid payments or hospitals that have a low-income

inpatient utilization rate greater than 25 percent) be eligible for these new payments, along with hospitals that provide at least 35,000 Medicaid days of care a year.

ASH estimates that only 870 of the country's approximately 4900 acute-care hospitals – 18 percent scattered throughout all 50 states and located in both urban and rural areas – would be eligible for these payments.

These supplemental payments would be eligible for federal Medicaid matching funds at an enhanced matching rate 6.2 percent greater than for the non-Medicaid expansion population – the same enhanced rate temporarily extended to states to help them through the COVID-19 public health emergency.

Other state government efforts to help hospitals with the greatest needs have at times been stymied by limits on how much state Medicaid funding the federal government will match. This program should overcome those obstacles by exempting these new payments from inclusion in the calculation of individual states' Medicaid disproportionate share hospital (Medicaid DSH) allotments; from their individual hospitals' OBRA (hospital-specific DSH) limits; from statewide Medicaid upper-payment limits; and from Medicaid payments when calculating cost-based reimbursement for Critical Access Hospitals. Instead, the maximum federal match for these payments would be equal to the federal share of 75 percent of the cost of providing care to individuals insured by Medicaid or with no third-party coverage (as defined for calculating the OBRA limit). New payments made in this manner would only be eligible for federal Medicaid matching funds if they supplement current state Medicaid payments and not supplant them.

Through this approach, hospitals serving the most challenged communities with the greatest health care needs would receive additional federal Medicaid resources to help them fulfill their mission.

Conclusion

For the reasons outlined in this brief paper, ASH believes government payers can take a major step toward fostering more equitable access to care, and a higher quality of care, in many of the country's most financially troubled and underserved communities by employing the methodologies described above to provide additional federal resources to the very hospitals that are in the best position to advance the cause of health equity.