ALLIANCE of SAFETY-NET HOSPITALS

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June 8, 2023

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-1850

Subject: 42 CFR Parts 411, 412, 419, 488, 489, and 495; [CMS–1785–P]; RIN 0938–AV08 Medicare Program; Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2024 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Rural Emergency Hospital and Physician- Owned Hospital Requirements; and Provider and Supplier Disclosure of Ownership

Attention: File Code CMS-1785-P

To Whom it May Concern:

I am writing on behalf of the Alliance of Safety-Net Hospitals, a group of private community safety-net hospitals that serve economically disadvantaged and underserved communities, to convey to the Centers for Medicare & Medicaid Services (CMS) our views on the proposed FY 2024 Medicare inpatient prospective payment system regulation that was published in the *Federal Register* on May 1, 2022 (Vol. 88, No. 83, pp. 26658-27309).

The Alliance of Safety-Net Hospitals (ASH) would like to bring to your attention our views on six aspects of the proposed regulation:

- proposed inpatient rates
- Medicare disproportionate share
- continuation of the low-wage hospital policy
- wage index treatment of hospitals reclassified as rural
- reasonable cost payment for nursing and allied health education programs
- health equity

We also respond to the safety-net hospital request for information.

Proposed Inpatient Rates

In the proposed rule CMS calls for increasing Medicare inpatient rates a net 2.8 percent. In ASH's view this is too little because it fails to reflect actual increases in health care costs and continues a troubling trend in recent years of inadequate Medicare rate increases that are having a demonstrable and negative effect on the financial health of community safety-net hospitals and others.

According to the report "*The Financial Stability of America's Hospitals and Health Systems Is at Risk as the Costs of Caring Continue to Rise*," published in April by the American Hospital Association, hospital labor costs rose 20.8 percent between 2019 and 2022; hospital supplies expenses rose 18.5 percent; prescription drug costs rose 19.7 percent; and hospitals' purchase of services costs rose 18 percent. Overall, the report concludes, hospital expenses rose 17.5 percent during the period between 2019 and 2022 while Medicare payments rose less than half as much during that same period: just 7.5 percent. A presentation delivered at a recent gathering of the American Health Law Association by the firm Health Policy Alternatives and co-written by a past 26-year veteran of CMS reinforces this conclusion, showing that CMS's 2.4 percent market basket increase for Medicare inpatient rates in FY 2021 fell well short of the inflation rate of three percent that year; that its 2.7 percent increase for FY 2022 was less than half of the 5.7 percent inflation rate that year; and that its FY 2023 increase of 4.1 percent was less than the 4.3 percent inflation rate. MedPAC agrees, writing in its March 2023 report to Congress that hospital costs have "exceeded the forecasts CMS used to set Medicare payment rates."

Even these figures do not tell the entire story. In 2019, for example, according to the 2022 American Hospital Association report "*Massive Growth in Expenses and Rising Inflation Fuel Continued Financial Challenges for America's Hospitals and Health Systems*," prior to the pandemic, 3.99 percent of the hours worked by nurses in hospitals were worked by contract or traveling nurses, accounting for a median of 4.7 percent of hospitals' nurse labor expenses. By January of 2022, however, contract and travel nurses accounted for 23.4 percent of all nursing hours worked in hospitals, which translated into a median of 38.6 percent of hospitals' nursing labor costs. While this crisis has abated to a degree, the situation has by no means returned to its pre-pandemic status; contract nurses continue to account for an outsized portion of hospitals' labor costs. This is important for two reasons: first, because of the increased expense; and second, *because the employment cost index used by CMS to calculate the market basket update includes only hospital-employed staff and not the contract staffing that hospitals have been forced to rely on more than ever in recent years.* Using such expensive staffing, moreover, is not a choice: it is a necessity, and without it, many hospitals would not be able to continue serving their communities as they always have because they would not have the staff to do so.

ASH believes the proposed market basket increase for FY 2024, like the increases in recent years, is inadequate, and hospitals have paid a severe price for these past payment shortfalls. According to the same AHA report,

> Because of this, margins have remained consistently negative, according to Kaufman Hall's Operating Margin Index throughout 2022… In fact, over half of hospitals ended 2022 operating at a financial loss – an unsustainable situation for any organization in any sector, let alone hospitals. So far, that trend has continued into 2023 with negative median operating margins in January and February. According to a recent analysis, the first quarter of 2023 saw the highest number of bond defaults among hospitals in over a decade. This also is one of the primary reasons that some hospitals, especially rural hospitals, have been forced to close their doors. Between 2010 and 2022, 143 rural hospitals closed – 19 of which occurred in 2020 alone. Finally, despite these cost increases, hospital prices have grown modestly. In fact, in 2022, growth in general inflation (8%) was more than double the growth in hospital prices (2.9%).

In other words, Medicare's hospital inpatient payments are falling further and further behind the actual increase in health care costs every year.

ASH believes the proposed FY 2024 Medicare inpatient rate increase will bring more of the same: it is not enough – not enough to cover the continuing rise of health care costs, not enough to keep pace with inflation, not enough to protect the financial health of hospitals that serve large numbers of Medicare (and other) patients, and, most important from ASH's perspective, not enough to meet the needs of community safety-net hospitals that serve especially high proportions of low-income, low-income Medicare, Medicaid, and uninsured patients. The financial health of so many of these hospitals is in jeopardy today – and with it, so is access to care in the largely low-income, highly diverse communities they serve across the country. For hospitals that serve large numbers of privately insured patients, this can be little more than an inconvenience; they can and do engage in cost-shifting, using revenue from their privately insured patients to compensate for their modest Medicare shortfalls. Community safety-net hospitals, highly dependent on their Medicare and Medicaid patients, know no such luxury: they have relatively few privately insured patients and must absorb every shortfall in Medicare payments in other ways – ways that detract from their ability to maintain their facilities, from the quality of the care they provide, from the breadth of services they can offer their often underserved communities, and from access to care for those underserved communities.

For these reasons, ASH urges CMS to use its special exceptions and adjustments authority to implement a retrospective adjustment in the FY 2024 final rule to account for the difference between the projected FY 2022 market basket and the actual market basket for that year – a difference of 3.0 percentage points. Such a payment update would be more accurate and fairer to hospitals and ensure their continued ability to provide quality care to their patients.

ASH also recognizes that CMS has an established methodology for calculating rate increases and relies on a specific source of data for those calculations. In our view, that data source is failing CMS and failing hospitals – especially community safety-net hospitals – for which fair Medicare rate increases are absolutely essential. CMS has the authority to change its methodology, and we encourage you to do so, to find a better data source because what the current source is producing today is not accurate and now risks creating victims of a methodology that at one time may have worked but clearly no longer does.

Medicare Disproportionate Share

ASH recognizes that the size of the Medicare disproportionate share Medicare DSH) uncompensated care pool is calculated based on a formula established by Congress and not one developed by CMS. Still, we cannot help but be disappointed to find that at the same time the federal government has so publicly focused greater attention and energy on addressing health equity challenges – including in this proposed rule – it also has proposed a cut of approximately $160 million in the Medicare DSH uncompensated care pool.

A cut of this size can only detract from the administration's health equity efforts because it would, without question, hit hardest the same community safety-net hospitals – including ASH hospitals – that serve the most patients who are challenged by social determinants of health and the most patients who have suffered, and who continue to suffer, from inequitable access to care. The federal government should not reach out to a specific population with one hand while taking resources away from it with the other. To the contrary, it should be consistent, and in this case that consistency, that walking the talk, means not taking much-needed resources away from the very hospitals that serve a population the administration has so

publicly and repeatedly and, we believe, appropriately, declared its intention to serve more effectively and with greater equity.

For these reasons, ASH opposes the proposed $160 million cut in Medicare DSH uncompensated care funds. If anything, we believe this pool should be larger, not smaller, to meet the needs of community safety-net hospitals and others that expect to continue serving large numbers of uninsured and underinsured patients. This is especially true in the coming year, with the unwinding of continuous Medicaid eligibility that characterized the recently ended public health emergency and amid the expectation that somewhere between five million and 14 million Americans will lose their eligibility for Medicaid in the coming months. While the proposed regulation at issue today addresses Medicare, CMS, as the implementation arm of so much federal health care policy, needs to be mindful of the whole picture, not just an isolated part of it, even in a proposed Medicare regulation that does not explicitly address Medicaid. Policymakers should not, in our view, be unmindful of the Medicaid changes now under way because if hospitals continue to find their financial health jeopardized by this confluence of circumstances – inflation, inadequate Medicare payments, loss of Medicaid coverage – more hospitals will falter and possibly even close, jeopardizing access to care for everyone, regardless of their insurance status. Again, ASH recognizes that the proposed cut is based on a formula established by Congress and not one developed by CMS, but we urge CMS to work within existing parameters to find a better approach to dealing with a decision that has significant implications for safety-net hospitals across the country.

Finally, ASH urges CMS to review the manner in which it calculated the Medicare DSH uncompensated care pool. Specifically, one of the components of that calculation, Factor 2, is determined by comparing estimates of the number of people projected to be uninsured in FY 2024 to the number of uninsured in calendar year 2013, before the Affordable Care Act took effect. The calculation for FY 2024 suggests that the uninsured portion of the population in FY 2024 will be the same as in FY 2023: 9.2 percent. ASH believes the FY 2024 figure could increase, however, and potentially increase significantly, because states may now disenroll individuals from their Medicaid rolls now that the continuous eligibility under the COVID-19 public health emergency has ended and it seems likely that many such disenrolled individuals may not be able to afford replacement insurance. For this reason, we urge CMS to update Factor 2 with more timely and accurate data to reflect this likely increase in the FY 2024 uninsured rate and then recalculate the Medicare DSH uncompensated care pool to reflect this more timely and accurate data.

Continuation of the Low-Wage Hospital Policy

In the proposed rule CMS calls for continuing temporary policies finalized it in its FY 2020 inpatient and LTCH rule to address wage index disparities affecting low wage index hospitals, including many rural hospitals.

As we have in the past, ASH wishes to convey its opposition to this approach that arbitrarily increases the wage adjustments of hospitals in the lowest quartile of wage adjustments and pays for the spending increases this produces with a budget neutrality adjustment to the standardized amount. While ASH recognizes that there may be valid reasons to believe the federal government needs to do something to increase Medicare payments to hospitals in certain low-wage areas of the country, despite the passing years CMS still has not identified any unfairness in how wage index adjustments are calculated or suggested that hospitals not in the lowest quartile have done anything untoward to gain their higher adjustments. This is a funding problem, not a formula problem, and ASH continues to believe that CMS's solution should not be to take money away from some providers to benefit others without a policy basis for doing so. Instead of applying what we believe to be an inappropriate, arbitrary, and unfair budget-neutrality adjustment, ASH urges CMS to work with Congress to secure new funding with which to assist hospitals in the lowest quartile

of wage index adjustments – if it continues to believe such assistance is needed – and to restore the associated payment reduction to all hospitals.

Wage Index Treatment of Hospitals Reclassified as Rural

CMS proposes interpreting the Social Security Act as directing it to treat rural reclassified hospitals the same as geographically rural hospitals for purposes of calculating their Medicare area wage index including a proposed revision to the methodology used to calculate the rural floor. It reached this decision in part as a response to legal challenges that had led to piecemeal policymaking regarding the treatment of hospitals reclassified as rural in recent years. Without commenting on any specific aspects of the implications of this new approach, ASH wishes to convey to CMS our appreciation for the agency attempting to add much-needed clarity to this situation and simplifying a matter that has become increasingly complex for interested parties in recent years.

Health Equity

CMS proposes a change in the severity designation of three ICD-10-CM diagnosis codes describing homelessness – from non-complication or comorbidity to complication or comorbidity – because of the higher average resource cost of cases with these diagnosis codes compared to similar cases without complications. ASH enthusiastically supports the proposal to introduce these z-codes and appreciates CMS's recognition that people experiencing homelessness often require more resources to treat than other patients with similar diagnoses. We believe this is an important step toward health equity.

Reasonable Cost Payment for Nursing and Allied Health Education Programs

Medicare pays for provider-operated nursing and allied health education programs on a reasonable cost basis. Under the reasonable cost payment methodology, a hospital is paid Medicare's share of its reasonable costs. Provisions of law enacted in 1999 and 2000 require that CMS include Medicare Advantage utilization in determining the Medicare share of a hospital's reasonable cost nursing and allied health education payments. These additional payments for nursing and allied health education attributed to Medicare Advantage utilization are funded through a reduction to analogous payments made to teaching hospitals for direct graduate medical education payments (DGME) and limited to $60 million a year.

An oversight resulted in CMS not updating the factors that went into determining Medicare Advantage nursing and allied health reasonable cost payments for more than 17 years. As a result, schools of nursing and allied health were paid more than $60 million annually over this period and CMS reduced DGME payments made to teaching hospitals more than was permitted under the law. When CMS discovered this problem it rectified it by paying money owed to teaching hospitals for DGME and recouping hundreds of millions in reasonable cost payments from hospital-based nursing and health education schools.

Section 4143 of the Consolidated Appropriation Act (CAA) of 2023 provides relief for hospitals subjected to recoupment of overpayments for 2010 through 2019 by not applying the $60 million payment limit to nursing and allied health education Medicare Advantage payments during these years. Section 4143 also provided that CMS shall not reduce a hospital's DGME Medicare Advantage payments to offset the increase in nursing and allied health Medical Advantage education payments. The proposed rule details the process CMS is instructing Medicare administrative contractors to use to implement section 4143.

ASH supports CMS's implementation of section 4143 to protect schools of nursing and allied health education from having to refund extra payments they received through no action of their own without reducing payments to hospitals that receive DGME payments.

Safety-Net Hospital Request for Information

ASH greatly appreciates CMS's expressed intention to begin addressing health equity in a more substantive manner. We would like to take this opportunity to share with you how we believe CMS should identify safety-net hospitals and to describe how we believe CMS can best help them.

Health Equity and Community Safety-Net Hospitals

Generally speaking, the communities private safety-net hospitals serve are characterized by significant health disparities driven in large part by inequities in the resources that have been invested in them over the years. As a result of these inequities, these communities face significant health challenges. The role of community safety-net hospitals has long been to work with their communities to address these health inequities. Because these hospitals primarily serve Medicare and Medicaid patients, they are paid less than other hospitals that serve more commercially insured patients, which is one of the most important reasons private community safety-net hospitals often lack the resources of other hospitals. Simply put, their public payers – Medicare and Medicaid – are not carrying their weight on a patient-for-patient basis. This same problem of lower reimbursement also hinders the ability of such hospitals to attract the physicians they need to serve their communities.

Because of this, community safety-net hospitals start out at a disadvantage. Lacking both the richer resources of private facilities with more commercially insured patients and the access to local, county, and state resources that public hospitals enjoy, private community safety-net hospitals often are older facilities that have aging medical equipment, lower operating margins, and smaller endowments. Even so, they routinely offer services they know will lose money because they know their communities need those services and have few other places to get them.

Despite these many challenges, community safety-net hospitals are continually testing new ways of doing a better job of serving their communities. In their constant pursuit of health equity they want to do more and need to do more, but they need the federal government, they need Medicare, to help them. While Medicare payments alone are not the root cause of some of these problems they are unquestionably a contributing factor and the federal government needs to do more to empower these hospitals financially to serve all of their patients, including their Medicare patients.

One way community safety-net hospitals strive to address social determinants of health is by providing services that no reimbursement system will ever capture and compensate them for delivering. They employ both social workers and care coordinators to connect low-income patients to community-based services; they transport patients to medical appointments; they send patients home with a package of prescription drugs instead of written prescriptions to have filled at their local pharmacy; they call their patients to make sure they are following up on their medical problems, have enough food to eat, enough heat, enough blankets; they hire translators to communicate more effectively; and much more. These are just some of the things community safety-net hospitals do in pursuit of health equity, to address social determinants of

health, and they are just some of the reasons ASH believes CMS can and should do more to join them in their efforts by providing much-needed supplemental funding.

CMS's Request for Information related to Defining and Identifying Safety-Net Hospitals

Introduction

In the proposed rule's request for information, CMS seeks stakeholder feedback on better ways to define safety-net hospitals for the purpose of more effectively supporting the first pillar in its strategic plan: advancing health equity. CMS notes in the preamble that "Although various approaches exist to identifying 'safety-net providers,' this term is commonly used to refer to health care providers that furnish a substantial share of services to uninsured and low-income patients." CMS goes on to acknowledge that "The Medicare statute also includes special payment provisions for other hospitals in underserved communities, including sole community hospitals, which are the sole source of care in their areas, as well as Critical Access Hospitals and Rural Emergency Hospitals" and concludes that "Given the critical importance of safety-net hospitals to the communities they serve, it is important to be able to identify these hospitals for policy purposes." Finally, CMS presents a detailed look at two potential methods for identifying safety-net hospitals: MedPAC's proposed safety-net index and area-level indices, specifically the Area Deprivation Index.

ASH believes there is value in applying different definitions to different policy goals, and in this response we use the term "safety-net hospital" to mean a hospital among those best able to address current disparities in health equity. It seems an appropriate term for this purpose because the "safety net" metaphor reflects the role of hospitals from the perspective of patients who might otherwise fall through the health care delivery system's cracks. If we are to address health equity, ASH believes we must identify those hospitals that are best positioned to help individuals suffering from health care disparities. We see this as distinct from the policy goal of financially supporting hospitals that provide a disproportionate share of their care to low-income and uninsured individuals. We believe this interpretation of the concept of "safety-net hospital" is necessarily defined by a hospital's ability to serve disadvantaged individuals and that to identify such hospitals we must start by identifying the communities such an undertaking needs to reach. It is from this perspective that ASH offers our views on some of the tools CMS suggests.

MedPAC's Safety-Net Index: ASH's View

ASH believes MedPAC's proposed Medicare safety-net index, while doing a good job of identifying hospitals deserving of additional financial support from Medicare, falls short as a means of identifying safety-net hospitals as defined in this request for information. Understandably, MedPAC's focus was on targeting Medicare resources to hospitals that care for low-income Medicare beneficiaries but it does so without regard for the role those same hospitals play in the lives of other low-income individuals. It also does not seek to identify the extent to which needy communities rely on individual hospitals.

While ASH believes MedPAC's safety-net index could be refined into a useful tool for identifying *Medicare* DSH safety-net hospitals, we believe it needs improvements if it is to be useful for identifying safety-net hospitals in general. Specifically, the index – currently the sum of hospitals' low-income Medicare share, uncompensated care share, and Medicare share – should be expanded to also include the hospital's Medicaid share, which is a critical measure of hospitals' financial dependence on government payment policies that are beyond its control.

The Area Deprivation Index: ASH's View

While ASH lauds the notion of identifying challenged communities through the use of area-level indices, we find less merit in any approach based on use of the area deprivation index (ADI). As part of our long-standing interest in finding better ways of identifying hospitals that should receive Medicare DSH payments and how those payments should be calculated we have explored numerous methodologies over the years and based on that work have concluded that the ADI is not an appropriate tool for identifying recipients of supplemental Medicare funding that would have the greatest impact on health inequities. Others share ASH's concern about the ADI, as the February 2023 *Health Affairs* article "ACO Benchmarks Based On Area Deprivation Index Mask Inequities" explains:

> Using national ADI benchmarks may mask disparities and may not effectively capture the need that exists in some of the higher cost-of-living geographic areas across the country. The ADI is a relative measure for which included variables are: median family income; percent below the federal poverty level (not adjusted geographically); median home value; median gross rent; and median monthly mortgage. In some geographies, the ADI serves as a reasonable proxy for identifying communities with poorer health outcomes. For example, many rural communities and lower-cost urban areas with low life expectancy are also identified as disadvantaged on the national ADI scale. However, for parts of the country that have high property values and high cost of living, using national ADI benchmarks may mask the inequities and poor health outcomes that exist in these communities.

The article also offers examples where CMS's use of ADI for similar purposes produces questionable results. Among them:

> ...New York City has both the richest and poorest congressional districts in the country (see exhibit 1). The South Bronx is considered the poorest congressional district in the country. The U.S. Small-area Life Expectancy Estimates Project uses census data from 2010 to 2015 to calculate life expectancy at birth at the census tract level, which we note is older data and a larger geographic area than the census block group used in ADI. Using this life expectancy measure, we see that much of the South Bronx has life expectancy between 69 and 75 years, which is in the lowest two quintiles nationally. The Upper East Side, which is part of the most affluent congressional district in the country, has life expectancy in the high 80s, which is the top quintile nationally. Under CMS's MSSP regulations—with the exception of only a few census block groups in the South Bronx—these areas in New York all fall into the more advantaged percentiles in national rankings of ADI, obscuring inequality and the needs of populations in the area.

ADI's two main shortcomings when evaluating its use in this context are its use of proxy information (including housing) rather than directly trying to identify community residents' health status and its use of national rather than local or regional comparisons of equity.

An Alternate Area-Level Index: ASH's "Health Equity Index"

ASH has long searched for better ways to define, identify, and reimburse true safety-net hospitals for the work they do. Through years of testing different data sources and modeling countless criteria and approaches we have developed our own methodology for doing what CMS seeks in this request for information: a better way to identify those safety-net hospitals best positioned to address health equity. We call our methodology our "Health Equity Index."

As CMS describes in the preamble to the proposed rule, area-level indices "are intended to capture local socioeconomic factors correlated with medical disparities and underservice." ASH's search for a means of identifying individual hospitals that are essential to access to care in their communities led us through a

variety of indices, including ADI, the Social Needs Index, the Social Deprivation Index, and other such measures. Most recently we developed our own index – what we call our "Health Equity Index" – working with the CDC's "PLACES" data and found it could be used to do a better, more precise job of identifying true safety-net hospitals than any of these other measures. PLACES data stands out from the others for creating a health equity index because it does not fit the description of an area-level index CMS uses in the preamble. It is *not* intended to capture factors associated with medical disparities; it is intended to capture the medical disparities themselves. We believe this distinction makes it much better suited for identifying the areas with the greatest opportunities to improve health.

Using a subset of available PLACES data, ASH's Health Equity Index is built on what we call a "Composite Health Disparity Score" that is created for each zip code. This Composite Health Disparity Score is the simple average of a zip code's z-scores in relation to the entire state's scores for each PLACES measure. The z-score represents how far above or below the mean score that zip code ranks for that measure.

Unlike many other indices, ASH's Health Equity Index measures relativity at a state rather than national level. ASH strongly believes that measures of equity must be made below a national level. Health care delivery systems are creatures of state influences such as licensure, regulation, the health insurance market, and Medicaid and CHIP program administration. If we are to influence health outcomes, we must measure them at actionable levels.

The Health Equity Index can then be used to identify the communities in each state with the greatest opportunities to improve health. We call these "Health Opportunity Zones" and define them as those zip codes with a Composite Health Disparity Score greater than one standard deviation above the mean Composite Health Disparity Score for the state in which they are located.

Finally, we define hospitals that provide more than 10 percent of the Medicare inpatient discharges or outpatient claims attributable to patients residing within a Health Opportunity Zone as "Critical Community Partner Hospitals" and believe these are precisely those that CMS seeks to identify as safety-net hospitals in this request for information.

ASH also has developed our own proposed methodologies for distributing additional Medicare resources to safety-net hospitals identified through this process. We have shared this methodology with MedPAC and you can learn more about it *here*, on the ASH web site, and we also have appended a description of ASH's proposal to advance health equity to this letter.

A Final, Vital Consideration: Resources

ASH believes the safety-net index developed by MedPAC would do a better job of recognizing the financial challenges associated with providing care to low-income, uninsured, and Medicare-covered populations than the current Medicare DSH methodology. We also believe the safety-net index would benefit from the Medicaid-related refinements we describe briefly above.

This request for information, however, is about health equity, and ASH does not believe the hospitals targeted for supplemental payments through the current Medicare DSH program are necessarily the same hospitals best positioned to advance health equity. If the administration is serious about addressing health equity for the Medicare population – and ASH believes it is – then CMS needs to identify the communities where health outcomes are unacceptable and provide additional financial resources to the hospitals that are serving those communities.

It is unreasonable to expect to be able to address social determinants of health and the health inequities they produce without making new, meaningful investments in the providers that do the most to undertake this challenge and that means new federal money. ASH is not unmindful of the challenge this poses in the current economic climate, but we also recognize that if health equity is truly a priority of CMS and the administration they need to make funding a program to address health equity a priority as well. ASH strongly encourages CMS to work within the Department of Health and Human Services and the administration, and with Congress, to make health equity a serious policy priority and to support that priority with the resources needed to make health equity solutions possible.

* * *

The Alliance of Safety-Net Hospitals appreciates the opportunity to respond to CMS's proposed inpatient prospective payment system regulation for FY 2024 and welcomes any questions you may have about the views expressed in this letter.

Sincerely,

Ellen Kugler, Esq.
Executive Director

About the Alliance of Safety-Net Hospitals

The Alliance of Safety-Net Hospitals is a coalition of like-minded community safety-net hospitals without dedicated sources of public funding that work together to advocate policy decisions on government health care programs, most notably Medicare and Medicaid, that ensure equitable access to care for the medically vulnerable residents of the communities they serve and adequate public resources for the safety-net hospitals that serve those communities.

APPENDIX

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A Proposal to Advance Health Equity

January 2023

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.