June 5, 2023

Introduction

On May 1, 2023, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule (CMS–1785–P) addressing guidance areas related to the Medicare program. As part of this proposed rule, CMS included a Request for Information (RFI) on Safety Net Hospitals. This RFI is part of CMS's health equity efforts under the agency's Strategic Plan.

In this communication, the National Organization of State Offices of Rural Health (NOSORH) provides input to CMS for the Safety Net Hospital RFI. NOSORH provides specific recommendations about what should be considered when designating safety net hospitals and how such a designation could be used. NOSORH also provides comments on the special circumstances of rural safety net hospitals.

NOSORH was established in 1995 to assist State Offices of Rural Health (SORHs) in their efforts to improve access to, and the quality of, health care for over 60 million rural Americans. All 50 states have a SORH, and each SORH helps their state's rural communities to build effective health care delivery systems. NOSORH and its members work closely with rural hospitals nationwide, including Critical Access Hospitals, Rural Emergency Hospitals and hospitals participating in the Small Rural Hospital Improvement Program. NOSORH brings its knowledge of rural essential community providers to the questions outlined in the RFI.

The concept of safety net hospitals – facilities providing hospital services that are essential to their communities – is an important one. Designating facilities that are vital to local communities provides the opportunity to craft program responses which can support their operations. The *essential community provider* designation, established under the Affordable Care Act, is a good example of how such designations can be applied.

NOSORH is encouraged that CMS is exploring how a new safety net hospital designation might be used for its various programs. In these comments, NOSORH suggests specific criteria that should be used in the designation of safety net hospitals. NOSORH also suggests how the safety net hospital designation could be used with several CMS programs. NOSORH provides, as an attachment, a decision-making flowchart illustrating how its suggestions for safety net hospital designation could be implemented.

Definition of Hospital

The first consideration in identifying whether a facility is a safety net hospital is whether that facility is to be considered a hospital. It is clear that general acute care hospitals should be included in any definition of 'safety net hospital'. Care at these facilities will typically include:

- General medical care,
- Surgical services,
- Obstetrics,
- Post-partum care,

- Pediatric care, and
- Emergency and trauma services.

NOSORH believes that other categories of acute care inpatient facilities should be included in any safety net hospital category, even if they provide a subset of typical services. These should include Critical Access Hospitals (CAHs) which might not provide a full range of inpatient services – for example, not providing obstetric care or surgical services. NOSORH also believes that the new category of facility identified by CMS, the Rural Emergency Hospital (REH), should be included in the definition of hospital.

Under CMS definitions, REHs do not have inpatient services other than those of an emergency department. This typically requires states to establish a new facility licensing category for REHs separate from that of other hospital categories. NOSORH believes that REHs are an important part of the rural health care system and recommends that REHs be included within any CMS definition of safety net hospital.

NOSORH notes that there are other categories of inpatient facility that are not acute care hospitals, including rehabilitation hospitals, long-term care hospitals and freestanding hospices. NOSORH does not believe that facilities which do not offer any acute care inpatient services or emergency department services should be included in the definition of safety net hospital. In the future, if CMS establishes a broader classification of essential community provider to be used for its programs, these facilities could be considered.

Designation Criterion - Exclusive Operations in a Service Area

For facilities considered to be hospitals, the first criterion to be considered in identifying a safety net hospital is whether there are competing hospitals providing equivalent care within the same service area. Sole Community Hospitals or other hospital facilities with no competition in a defined area would meet this criterion and should be designated automatically as safety net facilities. CAHs can also be included in this category, as they are designated as essential by nature of their relative geographic isolation from other providers or by a Governor's designation of their essential role in a service area.

This consideration of can be applied to facilities serving the general population or to those which serve a specific target subpopulation. For example, veterans' hospitals, tribal hospitals and IHS hospitals may be the only facilities serving these high needs populations on a targeted basis, even though they are physically located close to other facilities serving the general population.
NOSORH recognizes that there is also a need to examine the core service offerings of hospitals in competitive markets to understand if essential services are offered in only one facility. In such a case, that service could be considered a safety net service, and the hospital offering it could be a considered a safety net hospital for that offering. For example, if two hospitals are operating within the same service area, but only one offers obstetric services, that service is an essential part of the safety net for the community. Similar arguments can be made for communities with competitive hospital markets where only one facility is offering surgical services or higher-level trauma services. There needs to be a means of identifying fractional hospital services as part of a hospital safety net.

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Designation Criterion - Disproportionate Provider of Services to Key Coverage Groups

If a hospital is not otherwise designated as a safety net hospital based on its exclusive operations in a service area, NOSORH believes that there is an additional criterion that should be considered. In a competitive hospital market area, a hospital which provides a *disproportionate* share of service to vulnerable populations should be considered an essential part of the health care system and be designated as a safety net hospital.

NOSORH recommends that three important vulnerable populations be included in this review. The populations are defined by their health care coverage status:

- Medicaid/Child Health Insurance Program (CHIP) enrollees,
- Medicare enrollees, and
- Low-Income uninsured individuals.

Two of these groups receive publicly financed coverage and can include lower income enrollees. The last group is a target for state efforts to expand coverage.

NOSORH believes that publicly insured patients and low-income, uninsured patients can have more costly stays in hospitals This reflects poorer patient health resulting from the social determinants of health and more limited access to care. There is also the likelihood that low-income, uninsured patients will be less likely to afford follow-up care after discharge and will be more likely to have poor longer-term outcomes. This is significant for value-based reimbursement methodologies.

NOSORH suggests that the measure for this criterion be based on the total number of patient days for these target populations. NOSORH also recommends the use of an additional measure that captures the number of emergency department visits for each coverage group where the visit does not result in an inpatient admission. NOSORH notes that the criterion described in this section, while similar to that used in the Medicare and Medicaid DSH programs, is distinct. Among other things, there is no reference to SSI days. NOSORH has no specific recommendations for what level of service to these groups would define a *disproportionate* share, and suggests that this question be examined further, in consultation with appropriate advisory groups.

Special Challenges Facing Rural Safety-Net Hospitals

NOSORH has identified two factors that are particular challenges facing rural safety net hospitals – *low volume operatio*ns and *geographic accessibility*. These factors distinguish rural hospitals from urban facilities and should be given special consideration in the use of the safety net hospital designation. The two factors are discussed below.

Low Volume Operations: Most rural and frontier hospitals, including CAHs, are relatively low volume operations with unique challenges related to sustainability and quality/ performance measurement. *Sustainability* is the most pressing issue for rural hospitals. Multiple studies have highlighted the significant percentage of rural hospitals in financially stressful situations. Other

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studies have identified the number of rural hospitals which have closed over the last decade due largely to financial sustainability.

The recently implemented REH program is a lifeboat program for financially challenged rural hospitals. It gives them an opportunity to survive in exchange for a radical downsizing of their operations. The program is a recognition that full -service rural hospital operations are not, in many cases, financially viable – this in spite of the availability of programs providing differential payments and subsidies. When utilization volumes are low, income generated from bed occupancy will seldom be sufficient to assure the optimum level of rural community hospital capacity.

During the years when there was Federally supported comprehensive health planning, many states evaluated the need for hospital services in rural areas. This assessment included the need for general medical/surgical inpatient services as well as the need for specialty services such as obstetrics and delivery. Thirty-five (35) states, in a partial survival of comprehensive health planning, have some form of Certificate of Need (CON) mechanism to help regulate hospital capacity:

https://www.ncsl.org/health/certificate-of-need-state-laws

Generally, these efforts are to *limit* hospital capacity, rather than develop new capacity in locations where it might be needed. Truly comprehensive health planning should evaluate the need of communities for inpatient services and identify what financial resources are required to sustain the needed capacity.

The recent COVID-19 pandemic has highlighted just how problematic the lack of comprehensive health planning can be. Many rural and frontier hospitals did not have the capacity to manage the number of COVID-19 patients in their communities. Patients were transferred to regional hospitals, overloading those facilities. This circumstance led to national health policy discussions about the need to establish *standby* capacity in rural areas. Policy discussions also examined the need to create *surge capacity* at rural hospitals in preparation for future public health emergencies – capacity in excess of that which could be sustained by generated revenues and other regular sources of funding. These discussions provide an important perspective on what a hospital safety net might mean.

Quality and performance measurement is the second major challenge for low volume rural/frontier hospitals. The need for a different approach to this measurement has been recognized by the National Quality Forum:

https://www.qualityforum.org/Projects/n-r/Rural_Health/Final_Report.aspx

NOSORH's suggestions on this topic are discussed more fully in a subsequent section of these comments.

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Geographic Accessibility: Many rural/frontier residents face longer distances to health services than do urban residents. The absence of adequate public transportation in non-urban areas makes rural/frontier residents more reliant upon private vehicles. The result, for many rural/frontier residents, is higher travel costs – including both the cost of travel and the cost of foregone work time. For households with a single vehicle, the cost could be even higher, as more than one household member may need to forego work to help another get health care. Since many specialty/subspecialty services are not available locally, the cost of travel for these services, requiring trips to more distant cities, can be even higher.

This higher cost is part of a 'rural surcharge' on most health care use. This higher cost creates a barrier for the use of services, including appropriate follow-up services. Lower compliance with comprehensive care plans or hospital discharge plans can result, leading to poorer outcomes for patients in more remote communities. In recognition of the special circumstances of areas with extreme travel challenges, there is a need to adjust quality and performance standards for providers in those areas.

Use of a Safety Net Hospital Designation

There are multiple ways in which a safety net hospital designation could be used for program purposes. Safety net hospitals could be made eligible for ***payment differentials*** designed to help sustain their operations. Safety net hospitals might also be considered for ***adjustments to performance and quality measures*** – adjustments designed to reflect the different patient mix served by this category of facility. NOSORH's recommendations for how these two approaches could be implemented are discussed below.

Payment Differentials for Safety Net Hospitals: Payment systems, including Medicaid and Medicare payments, could establish payment adjustments for these safety net facilities. Many safety net hospitals in this category face higher operating costs which are not fully offset by generated revenues. Increased payments could help Improve the financial sustainability of these essential providers.

NOSORH notes that these payment adjustments will, in most cases, only *partially* defray the costs associated with hospital operation. Other mechanisms for subsidizing their operations will be required. NOSORH also notes that a hospital designated for a single essential hospital service, as recommended previously, should receive a payment differential only for that safety net service and not for all service offerings.

Quality and performance measurement adjustments: NOSORH believes that quality and performance measures used in the assessment of safety net hospitals should be adjusted before they are used in comparative analysis with non-safety net hospitals. Safety net hospitals typically provide services to patient populations with greater risk and disease severity than do non-safety net hospitals. This is true both for facilities which are the sole service provider for a given population as well as for facilities which serve a disproportionate share of publicly supported or indigent populations. The need for adjustment of risk and severity is a recognized topic in evaluation. The Agency for Healthcare Research and Quality (AHRQ) has addressed this issue:

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https://www.ahrq.gov/talkingquality/translate/scores/adjustment-scoring.html

NOSORH notes that the issue of risk and severity adjustment has specific relevance to CMS Hospital Value-Based Programs. These programs include the Hospital Acquired Conditions (HAC) Reduction Program, the Hospital Readmission Reduction Program (HRRP), and the Hospital Value-Based Purchasing (VBP) Program. These value-based programs tie performance and quality measurement to payment incentives. The incentives are based on the scoring of hospitals for purposes of ranking. Higher ranking hospitals receive payment incentives. Without appropriate risk and severity adjustment, safety net hospitals will be inappropriately penalized for their differential patient composition.

NOSORH believes that performance and quality measurement adjustments for rural safety net hospitals are particularly important. The Hospital Star rating system is example of the special problems faced by this segment of the hospital safety net. In 2018, NOSORH conducted a study of the Hospital Star Rating system and identified major problems with its treatment of rural providers. NOSORH's analysis indicated that fewer than half of all CAHs (48%) were able to report sufficient measures to be rated. For most of the indicators, CAHs did not meet the minimum reporting volumes required for a score. In addition, even among rated hospitals, fewer than 10% of all CAHs were rated on the important Patient Safety domain, compared to more than 90% of all acute care hospitals. This is very problematic. Similar problems exist in other measurement schemes, including that used by the VBPP.

NOSORH believes that no *single* set of measures and measurement standards can be established which will successfully allow comparison of quality and performance for all hospitals. This perspective is important for understanding safety net hospitals, and in particular, rural safety net hospitals. NOSORH recommends that measures and measurement standards should be established for *hospital cohorts/peer groups*, and that these peer groups should reflect a range of hospital characteristics, including hospital bed capacity, service offerings, rural location and safety net category. This will assure that a given facility's performance is being assessed compared to an equivalent hospital.

In a slightly different context, a good example of how peer group comparisons could be implemented is the County Health Rankings project of the Robert Wood Johnson Foundation. This project compiles county level health data for the nation and provides a tool that allows individual counties to compare their measures against peer counties. See the link describing this approach:

http://www.countyhealthrankings.org/peer-counties-tool

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Summary

NOSORH supports the efforts of CMS to improve health equity through creation of a Safety Net Hospital designation. NOSORH believes that designation of safety net hospitals should be a two-pronged effort, with some hospitals receiving an automatic designation based on the unique nature of their operations in the local market, and others receiving the designation based on analysis of their disproportionate share of high-risk patients in competitive markets. NOSORH trusts that its comments, particularly the comments addressing the nature of the

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