The Children's Hospital Association
Safety Net Designation Pediatric Provider Pathway
October 29, 2024

Executive Summary

Several stakeholder groups including the American Hospital Association (AHA) and America's Essential Hospitals (AEH) have recently proposed safety net hospital designation criteria with an eye toward linking such designation to funding sometime in the future. The federal government has no standardized designation for safety net hospitals. However, these proposed designations tend to exclude children's hospitals because they rely on Medicare-related metrics and exclude facilities that are exempt from the Medicare Inpatient Prospective Payment System (IPPS). In response to these proposed designations, the Children's Hospital Association (CHA) has developed a 'Pediatric Provider Pathway' that can be added to proposed safety net designations to more accurately reflect the critical role of Children's Hospitals as major pediatric safety net providers.

Background

The federal government has codified numerous hospital designations that are now tied to federal funding opportunities, including developing designations for Critical Access Hospitals, Designated Cancer Hospitals, Rural Emergency Hospitals, and Sole Community Hospitals.[1, 2, 3, 4] To date, there is no federal designation for safety net hospitals. More generally, safety net hospitals are viewed as hospitals that care for a large share of Medicaid, underinsured, and uninsured patients. Despite this shared mission, hospitals considered safety net facilities are structurally diverse with varying operations, patient populations, and service delivery systems, complicating efforts to consistently classify safety net hospitals. Multiple stakeholder groups, including the AHA and AEH, have developed proposed safety net hospital designations, with AEH supporting a bill (H.R. 7397) that would allow Congress to codify a safety net hospital designation that may later be used to direct federal funding to eligible hospitals. However, these proposed designations from the AHA and AEH rely heavily on Medicare-related metrics and exclude facilities that are IPPS-exempt, which puts many children's hospitals at a disadvantage and excludes others outright. Given the critical role that children's hospitals play in the pediatric safety net, it is essential that any federal designation for safety net hospitals provides an equal opportunity for children's hospitals to qualify.

[1] The Centers for Medicare and Medicaid Services designate Critical Access Hospitals through Section 1820(c)(2) of the Social Security Act. Available at: https://www.ssa.gov/OP_Home/ssact/title18/1886.htm
[2] The NCI Cancer Centers Program was created as part of the National Cancer Act of 1971. Additional information available at: https://www.cancer.gov/research/infrastructure/cancer-centers
[3] A final rule, effective January 1, 2023, established initial policies for Rural Emergency Hospitals (REHs) as a new Medicare provider type enacted in the Consolidated Appropriations Act (CAA) of 2021.
[4] The Centers for Medicare and Medicaid Services (CMS) designate Sole Community Hospitals through Section 1886(d)(5)(D)(iii) of the Social Security Act. Available at: https://www.ssa.gov/OP_Home/ssact/title18/1886.htm

Why should children's hospitals be considered safety net providers?

- Children's hospitals are the primary, regional providers for children with serious illnesses and complex conditions
- Children's hospitals disproportionately treat Medicaid patients, and provide nearly one-half of the inpatient hospital care for children covered by Medicaid
- Children's hospitals require highly specialized facilities, equipment, and staff and also provide programming and support services specifically designed for pediatric patients and their families
- Children's hospitals are vulnerable to financial risks from uncompensated care expenses and Medicaid payment shortfalls
- Children's hospitals play critical roles in their communities providing direct supports and services and bolstering the supports others in the community are able to provide children and families.
- Including children's hospitals in a safety designation will promote financial equity between the adult and pediatric safety nets

Although children's hospitals account for less than 5 percent of hospitals in the United States, they provide 47 percent of the inpatient hospital care for children covered by Medicaid.[5, 6] These hospitals serve as regional centers for children's health, offering care across large geographic areas and often treating children from across state lines. Notably, children's hospitals are the primary providers for children with serious illnesses, complex chronic conditions, and those needing major surgical services.[7] Delivering this essential care requires highly specialized facilities, equipment, and staff that are often unavailable at hospitals primarily treating adult patients. Children's hospitals also provide programming and support services specifically designed to meet the needs of pediatric patients that are not available at other facilities. Given that nearly 40 million children nationwide are covered by Medicaid, [8] potential federal funding tied to a future safety net designation may be particularly important for children's hospitals as Medicaid often fails to cover the cost of care. This leaves many pediatric providers vulnerable to financial risks from uncompensated care expenses and Medicaid payment shortfalls.

Existing federal statutes classify children's hospitals as those that primarily treat patients aged less than 18. These facilities are deemed exempt from the Medicare IPPS and some are eligible to receive Children's Hospital Graduate Medical Education (CHGME) funding. [9] Proposed safety net hospital designations from the AHA and AEH exclude IPPS-exempt facilities, meaning that many children's hospitals automatically fail to qualify. Simply adding the current classification of children's hospitals to the proposed safety net hospital designations falls short. Proposed designations from the AHA and AEH also rely heavily on metrics related to Medicare utilization, which means that even IPPS-eligible children's hospitals that operate within larger systems may also fail to qualify. In response to these proposed designations, CHA has developed a proposed 'Pediatric Provider Pathway' that may be added to existing designations in order to allow IPPS-exempt hospitals, as well as hospitals with high Medicaid

[5] The Children's Hospital Association. Response to CMS RFI. April 18, 2022.
[6] The Children's Hospital Association. Re: CMS-2408-P - Medicaid and Children's Health Insurance Plan (CHIP) Managed Care. January 14, 2019.
[7] The Children's Hospital Association. The Role of Children's Hospitals. December 21, 2023.
[8] US Department of Health and Human Services, New State by State Analysis on Impact of CMS Strategies for States to Protect Children and Youth Medicaid and CHIP Enrollment. December 18, 2023.
[9] 42 CFR § 256e

volume, an equal opportunity to participate.[10] Adding a Pediatric Provider Pathway to proposed safety net designations will ensure future designations are inclusive of a broad array of children's hospitals as major pediatric providers and appropriately reflect the structural and operational diversity of safety net providers.

Safety Net Hospital Designation Landscape

In partnership with Manatt Health, CHA used hospital cost report data and nationwide Medicaid claims data to estimate the number of children's hospitals that may qualify for the AHA and AEH proposed safety net designations. Results from these analyses revealed that most children's hospitals, and almost all acute care freestanding children's hospitals will fail to qualify for the AHA and AEH proposed designations due to the designations' reliance on Medicare-based metrics and IPPS eligibility.

American Hospital Association Metropolitan Anchor Hospital Designation

The AHA's Metropolitan Anchor Hospital designation is specifically limited to urban hospitals that participate in the Medicare IPPS, and requires that eligible facilities have a Medicaid inpatient utilization rate (MIUR) greater than the statewide average, along with either a Medicare disproportionate patient percentage (DPP) greater than 70% or a DPP greater than 34.5% combined with a ratio of uncompensated care costs (UCC)-to-beds of $35,000 or more. [11] We estimate that only 24% of children's hospitals overall (61 of 250) and only 6% (3 of 47) of acute care freestanding children's hospitals may meet the Metropolitan Anchor Hospital criteria. *See Table 1 for details.*

American Essential Hospitals Essential Health System Designation

AEH's Essential Health System designation classifies safety net hospitals as Medicare IPPS facilities that either meet Medicaid deemed disproportionate share hospital (Deemed DSH) criteria or have a Medicare uncompensated care payment factor (MUCF) greater than or equal to 0.0005. We estimate that nearly 50% of children's hospitals overall (120 of 250) may meet the Essential Health System designation but again only 6% (3 of 47) of acute care freestanding children's hospitals may qualify. *See Table 1 for details.*

Children's Hospital Association's Proposed Pediatric Provider Pathway

CHA has developed a Pediatric Provider Pathway that may be added to proposed safety net designations from the AHA and AEH to allow children's hospitals an equal opportunity to participate. The Pediatric Provider Pathway leverages metrics related to Medicaid payer mix, pediatric Medicaid diagnostic diversity, and receipt of CHGME funding. To qualify for the Pediatric Provider Pathway a hospital must have either an MIUR within the top 10% statewide or total Medicaid inpatient days within the top 25% statewide, and have either a pediatric Medicaid diagnostic diversity index[12] in the top 5% nationwide or be a CHGME recipient.

Adding the Pediatric Provider Pathway to the AHA and AEH proposed safety net designations dramatically increases the number of children's hospitals that may qualify for each designation. Results from our analysis revealed that leveraging the Pediatric Provider Pathway in addition to proposed criteria from the AHA may more than double the number of children's hospitals that would qualify, and

[10] Children's Hospital Association Responses to CMS RFI

[11] Exploring Metropolitan Anchor Hospitals and the Communities They Serve. October 2022.

[12] The Pediatric Hospital Diagnostic Diversity Index (HDDI), developed by CHA in collaboration with member hospital researchers, measures the scope and diversity of pediatric populations cared for in hospital settings based on the number of conditions managed by a hospital, adjusted for the distribution of hospital days across conditions. *See Appendix B for additional details.*

increase the number of children's hospitals that qualify for AEH designation from 120 to 180. Most notably, the Pediatric Provider Pathway, increases the number of acute care freestanding children's hospitals that may qualify for these designations from 3 to 44 across both AHA and AEH designations. *See Table 1 for details.*

Conclusion

Proposed safety net hospital designations from the AHA and AEH may be used to develop new federal designations that are tied to future funding opportunities, but these designations tend to exclude children's hospitals. In response to these designations, CHA developed a Pediatric Provider Pathway that may be integrated into existing safety net designations to broaden designation criteria to be more inclusive of the pediatric safety net, ensuring these vital providers receive an equal opportunity to participate in safety net hospital designations and addressing significant gaps in current designation design.

Table 1: *Children's Hospitals that Qualify for Proposed Safety Net Hospital Designations, 2019 – 2021*

Designation	**Total # of Children's Hospitals that Qualify** *(Total N = 250)*	**# of Acute Care Freestanding Children's Hospitals that Qualify** *(Total N = 47)*
AHA Metropolitan Anchor Hospital Designation	61	3
AHA Metropolitan Anchor Hospital Designation + Pediatric Provider Pathway	136	44
America's Essential Hospitals Essential Health System Designation	120	3
America's Essential Hospitals Essential Health System Designation + Pediatric Provider Pathway	180	44

Appendix A: Methodology Notes and Data Limitations

The analysis performed by Manatt Health leveraged publicly available datasets including Medicare hospital cost reports via the Healthcare Provider Cost Reporting Information System (HCRIS) and nationwide Medicaid claims data via the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF). HCRIS data were used to assess Medicaid and Medicare service volume, uncompensated care spending, and hospital geography in order to operationalize the AHA and AEH proposed safety net designations. TAF data were used calculate pediatric hospital diagnostic diversity indices. Data from CMS on the IPPS final rule were used to identify facilities that are / are not IPPS-exempt.

The analysis leveraged data from 2019, 2020, and 2021 which were the most recent years with complete HCRIS and TAF data available at the time the study was conducted. Metrics used to operationalize safety net designations for this analysis were based on pooled data over this three year period. For example, when calculating MIUR we divided the total number of Medicaid inpatient days from 2019 – 2021 for a given facility by the total number of inpatient days captured over the same time period.

The data sources used for this analysis have several notable limitations, including:

- Some hospitals, including children's hospitals, do not complete all sections of hospital cost reports, preventing researchers from calculating certain metrics, including MIUR for all facilities.
- HCRIS data and TAF data could not be linked for all facilities due to inconsistent hospital identifiers used in these data sources, preventing researchers from calculating pediatric Medicaid diagnostic diversity for some facilities.
- The pediatric hospital diagnostic diversity indices calculated for this analysis only reflect diagnostic diversity among Medicaid beneficiaries because the TAF data only contains information on Medicaid claims and enrollment
- HCRIS data is self-reported and is not uniformly audited by CMS
- HCRIS data on Medicaid volume and utilization capture both in and out-of-state Medicaid utilization, are not specific to pediatrics, and exclude individuals enrolled in comparable state-only funded programs.

Appendix B: Background on the Hospital Diagnosis Diversity Index and why it is included in the proposed Pediatric Provider Pathway.

We recommend including the Hospital Diagnosis Diversity Index (HDDI) in the proposed Pediatric Provider Pathway to recognize the breadth of diagnoses that children's hospitals treat, which is not represented by case mix alone. There is substantial variation in the pediatric conditions cared for and pediatric services offered across hospitals that provide inpatient care for children. The case mix index (CMI) has historically been used to measure the severity of patient populations in hospitals. However, since CMI is calculated as an average, it is driven by the largest patient volumes limiting its ability to compare the scope of services between hospitals (e.g., hospitals with similar CMI can care for vastly different patient populations).

CHA partnered with researchers at member hospitals to develop and publish a novel method, called the Hospital Diagnosis Diversity Index (HDDI), to measure the scope of pediatric populations cared for at hospitals. The HDDI is adapted from an ecological index used to measure the complexity of ecosystem (i.e., the Shannon-Wiener entropy index), and is interpreted as the number of conditions managed by a hospital, after adjusting for the distribution of hospital days across conditions. The original method was developed using 3M's APR-DRG classification system, but the index can be adapted for use with any classification system (e.g., MS-DRG, AHRQ Clinical Classification Software).

The HDDI was initially developed to help explain the variability in hospitalization costs between free-standing children's hospitals, general acute children's hospitals, and non-children's hospitals in the U.S. A published study found that adjusting for HDDI resulted in a nonsignificant difference in costs across all hospital types.[13]

Among its additional uses, the HDDI can be used to group U.S. hospitals into five meaningful types based on 1) the severity of a hospital's neonatal population and 2) the HDDI of its non-neonatal pediatric population managed (manuscript in process). This approach allows for hospitals to be characterized by the breadth, volume, and resource intensity of inpatient pediatric care provided, while still accounting for important differences in neonatal and other pediatric populations.

Traditional methods of classifying and comparing services across hospitals have not been grounded in a measurable set of attributes or services, and the metrics most often used make it difficult to clearly identify the patient populations or services that distinguish one hospital from another. In partnership with its members, CHA has developed a method for measuring and differentiating the scope of conditions managed among U.S. hospitals offering pediatric inpatient care.

[13] Berry JG, Hall M, Cohen E, Feudtner C, Chiang VW, Chung PJ, Gay JC, Shah SS, Casto E, Richardson T. Hospitals' Diversity of Diagnosis Groups and Associated Costs of Care. Pediatrics. 2021 Mar;147(3):e2020018101. doi: 10.1542/peds.2020-018101. PMID: 33627373.