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June 9, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1785-P
P.O. Box 8013
Baltimore, MD 21244–1850
Submitted electronically to http://www.regulations.gov

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

Dear Administrator Brooks-LaSure,

On behalf of over 200 children's hospitals across the country, the Children's Hospital Association (CHA) appreciates the opportunity to provide comments on CMS' Request for Information (RFI) on potential approaches to help safety-net hospitals meet challenges in providing quality care. We appreciate CMS's focus on developing a framework to identify safety-net hospitals and encourage CMS to consider safety-net provider criteria that is not overly reliant on Medicare-related metrics, which may exclude safety-net providers who traditionally care for a disproportionate number of uninsured patients and low-income Medicaid beneficiaries.

Children's hospitals are vital safety-net providers, treating children across the country who are uninsured, underinsured and enrolled in Medicaid. Though children's hospitals account for only 5% of hospitals in the United States, they provide 47% of the inpatient hospital care for children covered by Medicaid. On average, 50% of patients at children's hospitals are on Medicaid and some hospitals' percentages are 75% or more. Children's hospitals are regional centers for children's health, providing care across large geographic areas and serving Medicaid children across state lines. Children's hospitals serve the majority of children with serious illnesses and complex chronic conditions and most children in need of major surgical services. In addition, children's hospitals are engaged in efforts to promote delivery system changes, efficiency, quality improvements and cost savings in Medicaid. Given the critical role that children's hospitals play, we encourage CMS to consider a safety net designation framework that is inclusive of children's hospitals.

Safety-net hospital definitions overly reliant on Medicare metrics disadvantage and exclude children's hospitals and other providers who traditionally care for a disproportionate number of low-income Medicaid beneficiaries but have very low Medicare volumes. It is imperative that a safety-net designation framework recognizes the structural and operational diversity that exists amongst providers. The metrics utilized to identify safety-net hospitals should

acknowledge that the patients served have low access to healthcare and are disproportionately uninsured, underinsured and enrolled in Medicaid.

Many safety-net hospitals shoulder tremendous financial pressure and strain as they care for a disproportionate share of vulnerable patients. The cost of providing care is often not fully covered, leaving providers vulnerable to financial risks driven by uncompensated care expenses and Medicaid payment shortfalls. This cycle of perpetual underinvestment and underfunding contributes to health disparities and exacerbates access issues for marginalized, under-resourced and underrepresented communities. For many vulnerable patients, including children, care management services, linkages to community-based organizations and culturally responsive care would be unobtainable if not for Medicaid providers.

Safety-net hospitals face challenges providing physical and mental health care to children with serious, chronic or complex medical conditions and those who are underserved. The growing numbers of children in mental health crisis, many with suicidal ideation and self-injury, has led to an unprecedented surge in mental health visits to children's hospitals—and a shortage of beds and staffing needed to support those beds. Despite the profound need, there are too few pediatric mental health providers to ensure kids have access to the full continuum of care, from inpatient services to outpatient community-based services and supports.

Furthermore, the unparalleled numbers of children in need of inpatient pediatric care has placed an extraordinary burden on our frontline providers. Staff retention is a critical issue for children's hospitals and has impacted the amount of care they can provide. The workload pressures that grew under the COVID-19 pandemic are now exacerbated by the surges in other pediatric illnesses, including mental health. We are seeing nurses and other bedside staff reducing their work hours, with many others leaving health care completely. Some children's hospitals have been forced to resort to temporary staffing agencies to fill their workforce gaps, further straining financial resources. At the same time, there are some children's hospitals that have reduced their care capacity, with some forced to temporarily close entire pediatric intensive care units and other critical services, divert patients elsewhere or take other measures to address these unprecedented surges.

Tying funding to safety-net hospital status specifically would provide an opportunity to directly invest in safety-net hospitals and support sustainable service delivery for the communities in greatest need, including children. A holistic framework that is reflective of the structural and operational diversity of safety-net providers should avoid over-reliance on Medicare-related metrics and be inclusive of hospitals that disproportionately provide care to Medicaid beneficiaries and the underinsured. Specifically, this framework should explore including the following Medicaid factors: Medicaid inpatient utilization rate, low-income utilization rate, Medicaid payer mix, Medicaid deemed DSH status, diagnostic diversity and care complexity and hospital catchment area. Existing publicly available data sources including the Healthcare Cost Report Information System (HCRIS), the Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) and the Healthcare Cost and Utilization Project (HCUP) State Inpatient Utilization Database (SID) should be leveraged to identify safety net-providers. TAF data and HCUP SID data should be used to investigate metrics related to patients' diagnostic diversity / clinical complexity as well as hospitals' geographic catchment area. Additionally, providers should not be required to meet all metrics of interest in order to be classified as safety net providers.

We are working on a project to examine the best metrics to ensure children's hospitals are considered in any safety net designation and expect to have a more detailed perspective to share in the coming months. We ask for your partnership and collaboration in your safety net definition efforts going forward.

We thank you for the opportunity to provide comments and look forward to continuing to work with you to improve the delivery of children's health care. Please contact Natalie Torentinos at natalie.torentinos@childrenshospitals.org should you need more information.

Sincerely,

Aimee C. Ossman
Vice President, Policy Analysis
Children's Hospital Association