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State Politics and the Fate of the Safety Net
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Only 2% of acute care hospitals nationwide are safety-net facilities, but they provide 20% of uncompensated care to the uninsured. Because most are in low-income communities, they typically generate scant revenue from privately insured patients. The Medicaid Disproportionate Share Hospital (DSH) program was established to help defray their costs for uncompensated care.

Currently, Medicaid DSH disburses $11.5 billion annually to the states, which have considerable latitude in allocating these funds. Some states carefully target their DSH payments to hospitals providing large volumes of uncompensated care, but others, such as Ohio and Georgia, spread their payments broadly, transforming the program into a de facto subsidy of their hospital industry.

Because the Affordable Care Act (ACA) was expected to dramatically expand insurance coverage, safety-net hospitals were expected to need less DSH money. Therefore, to reduce the cost of expanding Medicaid, the ACA reduced Medicaid DSH funding by $18.1 billion between fiscal years 2014 and 2020. To allow time for coverage expansion to take effect, the cuts are back-loaded — starting at $500 million (4% of current national DSH spending) in 2014 but reaching $5.6 billion (49% of current spending) in 2019.

The DSH cuts are so deep in part because Congress assumed that all states would expand Medicaid, providing coverage for 17 million low-income people and sharply reducing uncompensated care. The anticipated increased revenue from Medicaid was considered sufficient to compensate hospitals for lost DSH funds. The fiscal math changed when the Supreme Court ruled that states could opt out of Medicaid expansion. Now, only 24 states and the District of Columbia plan to expand Medicaid in 2014; 22 states, including Texas and Florida, will not, and the rest are undecided. Thus, at least 6 million Americans who were expected to obtain coverage will remain uninsured. Because many states that won’t expand Medicaid currently receive large DSH payments, their safety-net hospitals will be hit hard when the DSH cuts kick in.

Even states that expand Medicaid will need some DSH support. After Massachusetts implemented its health care reform law, uncompensated-care costs at its hospitals dropped by 40% but soon climbed again. In 2011, Massachusetts hospitals required $440 million to offset their costs for uncompensated care.

Recently, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule allocating reductions in DSH payments across states for the first 2 years, on the basis of three equally weighted factors: the percentage of uninsured people in the state, how well the state targets its DSH payments to hospitals with high percentages of Medicaid inpatients, and how well it targets DSH payments to hospitals with high levels of uncompensated care. If the rule is adopted as written, states with lower percentages of uninsured citizens will receive steeper cuts, but the biggest reductions will hit states that don’t target DSH payments to hospitals providing large amounts of Medicaid and uncompensated care.

We believe the proposed rule moves DSH policy in the right direction by providing incentives to states to focus their remaining DSH funds on the hospitals that need it most. The proposed rule does not change states’ authority to use DSH funds for a broad hospital subsidy, but those...
that do will get less money (see table and the Supplementary Appendix, available with the full text of this article at NEJM.org). For example, Texas faces one of the biggest proposed reductions in its baseline DSH allocation (–5.5%, a cut of $56.1 million) because it broadly allocates DSH funds to hospitals that provide little uncompensated care. In contrast, California targets its DSH money to only 4% of its hospitals and will therefore receive a much smaller proportionate reduction of 2.8% (a cut of $32.6 million).

The proposed rule lasts only 2 years and doesn’t consider states’ decisions about Medicaid expansion. By waiting to see whether additional states expand Medicaid or retarget their DSH funds, CMS will have more information to guide future rulemaking. But as matters stand, states that refuse to expand Medicaid and to target DSH payments more carefully will not only forfeit billions of dollars for covering their poorest residents; they will also forgo hundreds of millions more when DSH cuts are ramped up in 2017. If politics continue to trump economic self-interest in these states, the consequences for their safety-net hospitals could be dire.

Widespread opting out of Medicaid expansion creates a new urgency to rethink DSH policy. Congress and CMS have three options.

First, they could postpone or rescind the DSH cuts — the course being urged by America’s Essential Hospitals (previously the National Association of Public Hospitals and Health Systems). Their case was bolstered when the President’s 2014 budget called for delaying the cuts until 2015. Given the ferocity of current battles over health care spending, we doubt...
Improving Patient Safety through Transparency

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Transparency — especially when things go wrong — is increasingly considered necessary to improving the quality of health care. By being candid with both patients and clinicians, health care organizations can promote their leaders’ accountability for safer systems, better engage clinicians in improvement efforts, and engender greater patient trust. Today, many institutions have initiated efforts to improve the sharing of information on publicly reported performance measures, but transparency regarding medical errors has proved much more difficult to achieve.

U.S. health care organizations still have a ways to go to achieve a culture in which all errors are openly identified and investigated. Ideally, the primary goal of these investigations is not punitive, but rather to understand what happened and facilitate open discussion in order to prevent similar mistakes from happening again. National surveys on the patient-safety culture of medical offices and hospitals consistently reveal substantial room for improvement in achieving these aims.1 Last year, less than two thirds of staff members reported having a favorable perception of their hospital’s openness in communication, and less than half reported that their hospitals respond to errors in a non-punitive way.

Fortunately, there are some bright spots that demonstrate progress toward greater openness. For example, we have seen steady growth in the number of safety reports filed by clinicians now that institutions routinely