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DOI: 10.1056/NEJMp1307643
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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.[1]

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.[1]

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.[2] To allow time for coverage expansion to take effect, the cuts are backloaded — 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[3] 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.[4] Thus, at least 6 million Americans who were expected to obtain coverage will remain uninsured.[3] 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.[2] 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

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Proposed Medicaid Disproportionate Share Hospital (DSH) Allotments for Fiscal Year 2014 and Reductions for States with Baseline DSH Allotments Greater Than $200 Million.*

State	Plans to Expand Medicaid in 2014	Baseline DSH Allotment	Amount of DSH Reduction	Percent DSH Reduction
		dollars		
Alabama	No	327,306,706	16,867,229	5.15
California	Yes	1,166,861,709	32,623,078	2.80
Connecticut	Yes	212,882,410	13,330,772	6.26
Florida	No	212,882,410	10,091,455	4.74
Georgia	No	286,060,738	11,074,410	3.87
Illinois	Yes	228,848,590	10,843,227	4.74
Indiana	No	227,518,076	7,608,722	3.34
Louisiana	No	731,960,000	25,345,450	3.46
Massachusetts	Yes	324,645,675	16,721,329	5.15
Michigan	Yes	282,069,193	13,445,466	4.77
Missouri	No	504,265,209	25,903,421	5.14
New Jersey	Yes	685,215,257	29,349,180	4.28
New York	Yes	1,709,711,855	65,531,526	3.83
North Carolina	No	314,001,555	14,297,361	4.55
Ohio	Undecided	432,417,395	23,409,393	5.41
Pennsylvania	Undecided	597,401,262	33,866,647	5.67
South Carolina	No	348,594,946	13,712,319	3.93
Texas	No	1,017,844,022	56,136,869	5.52

* The 18 states with baseline DSH allotments of $200 million or more in fiscal year (FY) 2014 account for 82% of the national baseline DSH allotment. These baseline allotments are the amounts that states would have received in the absence of the DSH cuts. Information on states' plans to expand Medicaid is based on their status on September 3, 2013, as reported by the Kaiser Family Foundation.[4] The FY 2014 baseline DSH allotments, amount of DSH reductions, and percent of DSH reductions were published as estimates by the Centers for Medicare and Medicaid Services in the proposed Medicaid DSH Allotment Reductions rule and could change in the final rule.[2] An expanded version of the table is provided in the Supplementary Appendix.

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[5]; 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

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that Congress will restore DSH to its previous level. And even such a restoration would not solve the underlying structural problem of poor targeting by states. Moreover, reopening DSH for debate could result in even bigger cuts.

The second option is to create even clearer incentives for states to target their remaining DSH funds. CMS could retain the current framework for allocating states' shares but set a higher bar for identifying DSH providers, on the basis of the overall profile of a state's hospitals, not just the hospitals currently receiving DSH funds. This approach would provide incentives to states that don't target their DSH allocation to do so, without penalizing those already doing a good job.

The third option is to recognize that the Medicaid DSH program has largely become a federal program, with few state dollars supporting it.[1] Since the federal government is paying the tab, Congress could adopt a straightforward, national formula for determining hospital eligibility and DSH payment amounts. Support would thus be directed to safety-net facilities that serve important national health security interests, such as operating full-service emergency departments, participating in their state's trauma care system, and anchoring their region's disaster plan.[1]

If properly enforced, the proposed rule will help sustain the safety net. But if the state governments that refused to expand Medicaid also refuse to rethink their approach to allocating DSH funds, there will be little money left to sustain their safety-net hospitals when the cuts deepen in 2017. The cascade of service reductions and facility closures that this could trigger would have sweeping consequences. Safeguarding the safety net in such politically perilous times will require creative rulemaking by CMS. The proposed DSH rule is a good start, but much remains to be done.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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This article was published on September 18, 2013, at NEJM.org.

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DOI: 10.1056/NEJMp1310572

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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 nonpunitive 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

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