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Essential but Undefined — Reimagining How Policymakers Identify Safety-Net Hospitals

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Defining what counts as a safety-net hospital has long been a challenging but critical issue in U.S. health policy. The Covid-19 pandemic has brought this subject to the fore, as Congress and the Department of Health and Human Services (HHS) have struggled to operationalize a strategy for distributing Covid-19 relief funds to the hospitals that need them most. U.S. safety-net hospitals provide essential care to patients regardless of their insurance coverage, financial circumstances, or immigration status. The disproportionate share of uncompensated care that these hospitals provide often leads them to operate with thin financial margins while assuming responsibility for providing services that are critical but often unprofitable, including inpatient psychiatric services, neonatal intensive care, and burn and trauma care. In addition, these facilities often fulfill local community needs, such as offering food pantries and housing-assistance programs, and they represent an important source of employment. They are also the primary sites of care for many non-White communities and structurally marginalized populations.

The National Academy of Medicine has defined safety-net providers as those that, by mandate or mission, offer access to services regardless of a patient's ability to pay, and whose patient population includes a "substantial share of . . . uninsured, Medicaid, and other vulnerable patients."[1] It's not clear, however, which hospitals fall into this category. This definition is an aspirational but imprecise one — what constitutes a "substantial share" of patients, and what criteria should be used to assess which patients qualify as "vulnerable," beyond simply being covered by Medicaid or lacking insurance?

The absence of a clear definition for safety-net hospitals has made it difficult to effectively target pandemic-related resources. The Coronavirus Aid, Relief, and Economic Security (CARES) Act, passed in March 2020, initially allocated funds to hospitals on the basis of their number of Covid-19 cases. However, this allocation system didn't account for the fact that safety-net hospitals had fewer resources than other hospitals at baseline and were therefore less able to respond to the pandemic early on. To address this disparity, in May, HHS distributed $2 billion in add-on funding to hospitals on the basis of their Medicare Disproportionate Share Hospital

(DSH) percentage, which is equal to the sum of a hospital's share of Medicaid-insured patients and its share of low-income Medicare-insured patients.[2]

Later, HHS proportionately allocated additional funding to hospitals on the basis of their historical patient-revenue levels. But this approach ignored the disproportionate amount of uncompensated Covid-19 care provided by safety-net hospitals. In June, HHS acknowledged this omission and dedicated another $10 billion to safety-net hospitals, which it defined as hospitals meeting three financial criteria: low profitability (overall profit margin of 3% or less), high levels of uncompensated care (at least $25,000 per bed per year), and a high Medicare DSH percentage (at least 20.2%). Because these criteria didn't account for fluctuations in hospital finances, to which safety-net hospitals can be particularly susceptible, HHS again expanded its criteria in July and allocated $3 billion to 215 hospitals that met the profitability threshold when their profits were averaged over at least 2 of the past 5 years. Serial attempts to define safety-net hospitals resulted in delayed funding for many facilities. Communities of color have been disproportionately affected by Covid-19; hospitals serving patients from these communities in particular need more support.[3]

Part of the confusion stems from the federal government's use of multiple approaches for classifying facilities as safety-net hospitals. Medicare and Medicaid have separate DSH programs designed to provide subsidies to hospitals with a large percentage of Medicaid-insured and low-income patients. Receipt of Medicare or Medicaid DSH payments isn't the only way to define safety-net hospitals, but it's the primary means by which the federal and state governments allocate funding to hospitals that serve predominantly these patients.

The Medicare and Medicaid DSH programs use different criteria to determine hospital eligibility. As described above, hospitals qualify for Medicare DSH payments on the basis of their DSH patient percentage. This definition attempts to capture patients of limited financial means, but it excludes uninsured patients.

States use various approaches to allocate the more than $12 billion in annual federal funds provided under the Medicaid DSH program. All states must allocate Medicaid DSH payments to "deemed DSH" hospitals, which serve the highest share of Medicaid-insured and low-income patients, as defined by thresholds established by federal statutes. But states still have tremendous flexibility to determine what constitutes a safety-net hospital outside these parameters and to allocate funds. Some states distribute funds to a few hospitals that serve critical safety-net functions, whereas others distribute funds to nearly every hospital within their borders. The consequences of these differing strategies for patient outcomes have yet to be evaluated, largely because of the opaque processes involved. However, the Medicaid and CHIP (Children's Health Insurance Program) Payment Access Commission has consistently found "little meaningful relationship" between a hospital's receipt of Medicaid DSH payments and its uncompensated care costs, fraction of uninsured patients, or provision of safety-net services — findings that indicate poor targeting of these funds.[4]

Outside the DSH programs, several other definitions of safety-net hospitals have been proposed. The choice of definition has important policy consequences. First, the samples of hospitals included under various definitions may provide different services and serve different communities. When applied nationally, definitions based on uncompensated care tend to include primarily small, rural hospitals; definitions based on the proportion of Medicaid-covered or uninsured patients or the Medicare DSH patient percentage include primarily larger, urban hospitals.[5]

Second, federal pay-for-performance programs continue to grapple with multiple issues related to these definitions. Safety-net hospitals were twice as likely as other hospitals to be penalized under Medicare's Hospital Readmissions Reduction Program (HRRP) and under several other programs that tie Medicare payments to performance on quality measures. In the 21st Century Cures Act, Congress required the HRRP to compare hospitals in the same "peer group." Peer groups are determined according to the fraction of a hospital's patients who are dually eligible for Medicare and Medicaid. This narrow definition, however, excludes hospitals serving predominantly people with only Medicaid coverage or uninsured patients, and the policy's effect depends on the generosity of states' Medicaid eligibility thresholds.

For all these reasons, there is renewed urgency to more accurately determine what constitutes a safety-net hospital. Policymakers typically use a binary approach: hospitals either do or do not

qualify, depending on certain thresholds. In reality, there are hospitals on both sides of these arbitrary thresholds that serve a safety-net function. We believe that policymakers should stop trying to define safety-net hospitals per se and start defining safety-net services.

This strategy could involve moving toward a composite "sliding-scale" measure of safety-net status. Such a scale could include, for example, a hospital-level measure of the composition of the patient population (proportion covered by Medicaid, or the Medicare DSH percentage), a geographic measure of socioeconomic disadvantage (area deprivation index, county-level poverty rate), a measure of the proportion of services that are provided to racial- and ethnic-minority populations, a measure of hospital finances (amount of uncompensated care, operating margin), and a measure of hospital investments in the community (amount of community-benefit spending, provision of essential-but-unprofitable services). If safety-net hospital status were measured on a continuum, federal aid or Medicaid DSH funds could be allocated according to a hospital's position on a sliding scale. Similarly, peer comparisons under pay-for-performance and alternative payment models could be performed by grouping hospitals that fall close together on the scale. Such a strategy could gradually steer the United States away from a tiered hospital system in which safety-net functions are concentrated among a few facilities and away from an overreliance on arbitrary thresholds.

An audio interview with Dr. Chatterjee is available at NEJM.org

A continuum-based approach to defining safety-net hospitals isn't without shortcomings. Applying weights to various factors would require stakeholders to agree on what the functions of safety-net hospitals should be, while acknowledging that such functions will vary among communities. But the current approach to characterizing safety-net hospitals limits policymakers' ability to effectively target resources. Supporting these facilities is now more important than ever, and understanding how best to do so will be increasingly vital.

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Medicaid and Child Health Equity

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Medicaid and the Children's Health Insurance Program (CHIP) insure roughly 35% of all U.S. children (see graph). Apart from the elderly, no other age group depends more on public benefits or has more of a stake in the debate over the role of a strong public insurance system in achieving greater health equity. For children, no other insurer has equaled Medicaid's comprehensive coverage and cost-sharing protections. But Medicaid, even as enhanced by CHIP, also has important limitations. Means testing restricts eligibility, and low provider payments create access problems for enrollees. Furthermore, federal Medicaid funding is tied to state spending. Even in normal times, this funding scheme places a substantial burden on states. But these are not normal times, and the Covid-19 pandemic has exposed many deep fissures in the U.S. health system.[1]