What defines a safety-net hospital?

September 8 2023

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Safety-net hospitals have a common mission to provide care for Medicaid beneficiaries and those who are uninsured, but there's no universal definition for these hospitals—complicating efforts to allocate funding.

In a new analysis published in *JAMA Network Open* and led by researchers at the NYU School of Global Public Health, the research team looked at five established definitions for safety-net hospitals and found that different criteria captured varying hospitals and characteristics. As a result, when the Centers for Medicaid and Medicare Services (CMS) use one definition to allocate funding, some hospitals are excluded and may not receive the necessary funding to continue providing care.

In an effort to characterize the safety net and inform hospital funding decisions, policymakers and researchers have developed a range of definitions for safety-net hospitals, taking into account factors such as uncompensated care costs, hospital ownership, and patients covered by Medicaid. One such definition, Disproportionate Share Hospital (DSH) payments, was developed by CMS to allocate funding to safety-net hospitals. DSH payments are calculated based on the share of care provided to patients receiving social security payments, Medicare coverage, and Medicaid coverage.

In their analysis, the researchers looked at the characteristics of 5,955 U.S. hospitals captured in the 2020 American Hospital Association Annual Survey. They applied five different definitions of safety-net hospitals: those with the most DSH payments, Medicaid inpatient days, Medicaid inpatient days or public hospitals, public hospitals or teaching hospitals, and public hospitals. They also looked at different characteristics of the hospitals, including whether they were rural, for profit or nonprofit, number of beds, whether they were in a Medicaid expansion state, and the clinical complexity of their patients.

The analysis found that each safety-net definition encompassed a considerably different set of hospitals with varying characteristics. For instance, defining safety-net hospitals using only DSH payments accounted for 11.4% of U.S. hospitals and included the fewest rural and

public facilities, while defining safety-net hospitals as public or teaching hospitals encompassed more than half (55.2%) of hospitals.

The researchers recommend the adoption of a universal definition or safety-net hospital index to create a more precise tool to identify hospitals for funding.

"This index should incorporate characteristics beyond financial expenditures to include community and service characteristics that can better capture which hospitals care for vulnerable populations," said Elizabeth McNeill, a doctoral candidate at the NYU School of Global Public Health and the study's first author.

They also note the risk of allocating funding based on Medicaid care in light of uneven Medicaid coverage across the country. States that have not expanded Medicaid coverage may increase the proportion of uninsured individuals who need care from safety-net hospitals, driving up their costs for uncompensated care.

"Employing a definition for safety-net hospitals based on Medicaid days will underestimate the needs of hospitals in non-expansion states," said Ji Chang, assistant professor of public health policy and management at NYU School of Global Public Health and the study's senior author. "A universal definition or index that includes hospital services in addition to Medicaid care would identify more facilities as safety-net hospitals in these states."

More information: Elizabeth McNeill et al, Variance of US Hospital Characteristics by Safety-Net Definition, *JAMA Network Open* (2023). DOI: 10.1001/jamanetworkopen.2023.32392

Provided by New York University