

HEALTH CARE REFORM

Patient Satisfaction and Safety-Net Hospitals

Carrots, Not Sticks, Are a Better Approach

SAFETY-NET HOSPITALS (SNHS) PROVIDE A DISPROPORTIONATE share of care to uninsured and Medicaid patients. Because they have few privately insured patients, SNHS cannot cover the costs of uncompensated care for the uninsured by charging higher fees to insured patients. As a result of the heavy burden of uncompensated care for the uninsured and inadequate Medicaid reimbursement rates, most SNHS have negative operating margins.¹

Under the Patient Protection and Affordable Care Act (ACA),² many uninsured patients will gain coverage. This increase in coverage will help SNHS because they will likely have more paying patients. However, another provision of the ACA, a reduction in the Medicaid and Medicare Disproportionate Share Hospital (DSH) programs, may result in SNHS losing more money than they gain through the insurance expansion. The DSH programs provide supplemental payments to hospitals that deliver a disproportionate volume of care to uninsured patients and Medicaid recipients. The ACA requires a \$14 billion cut in Medicaid DSH and a \$22 billion reduction in Medicare DSH payments from 2014 through 2019.³ These cuts could have a devastating effect on the already precarious finances of SNHS, especially if they are unable to attract or retain newly insured patients.

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As SNHS grapple with these unprecedented cuts, they will face additional challenges under Medicare's Value-Based Purchasing (VBP) program that are highlighted by Chatterjee et al⁴ in this issue of the *Archives*. Chatterjee et al⁴ found that SNHS have lower patient satisfaction scores than non-SNHS and that the gap in scores has widened over the past few years. Since VBP will penalize hospitals that score below the national medians for patient satisfaction scores, SNHS are likely to lose a proportion of their Medicare revenue to non-SNHS.

Value-based purchasing will incentivize hospitals to improve their scores for patient experience and quality measures by rewarding the winners in the top half with increased payments and penalizing the losers in the bottom half with decreased payments.⁵ Hospitals are rewarded more for achieving higher patient satisfaction scores compared with other hospitals than for their relative improvement and are penalized for lower patient satisfaction scores, which will hurt SNHS that start at a disadvantage. Because SNHS take care of many patients without the ability to pay, some with conditions that re-

quire extra resources (eg, social work, behavioral health care), the hospitals may not have the resources to devote to physical plant improvement or other amenities that affect patient satisfaction. Long waits due to the heavy demand for services that are not available anywhere else for uninsured or Medicaid patients may result in patients feeling dissatisfied with their care.

Moreover, previous studies have failed to demonstrate a strong relationship between patients' experiences and quality of care.^{6,7} In a recent study, higher patient satisfaction was associated with higher expenditures for overall health care and prescription drugs as well as increased mortality.⁸ This emerging research suggests that factors other than the quality of care may drive patient satisfaction and that incentive systems based on patient satisfaction could have unintended consequences on health care utilization and outcomes.

While it is important to improve quality at SNHS, the VBP program could push SNHS closer to the brink of bankruptcy. Safety-net hospitals that are already drained by the DSH reductions are likely to lose additional funds under this program, leaving them without any capital to launch initiatives to improve quality and patient experience. Over time, VBP could worsen the disparities between prosperous non-SNHS and struggling SNHS.

It would be a tragedy if the combined stressors of the DSH cuts and VBP trigger the closures of SNHS. These hospitals will still be needed to care for the estimated 23 million individuals who will remain uninsured even if health care reform is fully implemented.³ If the Supreme Court strikes down the individual mandate but upholds the rest of the ACA, an estimated 16 million fewer Americans would obtain insurance. Safety-net hospitals would continue to be inundated with the 39 million uninsured individuals who would continue to seek charity care.

The closures of SNHS would also be detrimental to the millions of insured Americans who rely on them for specialized services such as trauma care, disaster relief, burn treatment, neonatal intensive care, psychiatric care, and substance abuse treatment. These unprofitable services are more likely to be offered by SNHS than non-SNHS.⁹ Safety-net hospitals are also essential sites for medical education.

Safety-net hospitals are already highly motivated to improve patients' experiences by decreasing wait times, enhancing customer service, and investing in patient amenities.¹⁰ They realize that their survival under health care reform depends on their ability to retain their newly insured patients to ensure a significant level of revenue to support the care of the remaining uninsured. Because of

inadequate resources, SNHs may struggle to simultaneously improve patient experience and launch the quality improvement initiatives necessary to succeed under VBP.

Safety-net hospitals have demonstrated that they can improve their quality of care under financial incentives in pay-for-performance programs.¹¹ The Delivery System Reform Incentive Program in California, created under a Medicaid section 115 waiver, is one promising model for how the Medicaid program can use financial incentives to support SNHs in building the infrastructure to improve quality of care *and* patient experience.¹² Public hospitals in California will receive up to \$3.3 billion in matching federal payments over 5 years by meeting milestones that include process and outcome quality measures and patient satisfaction. The Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies should design incentive programs that reward SNHs for improving patient experience and quality with the goal of closing the gap between SNHs and non-SNHs before implementing penalties.

The pursuit of value-based care is a worthy goal for SNHs. In its zeal to drive improvement, CMS should consider the precarious finances of SNHs under health care reform. By continuing to support SNH incentive programs, CMS can provide vital resources for quality improvement and avoid a financial crisis among SNHs.

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Correction

Error in Signature Block. In the Editorial titled "The JAMA Network Journals: New Names for the Archives Journals" (2012;172[14]:1056), published in the July 23, 2012 issue, an error occurred in the signature block. The middle initial for Rita Redberg was incorrectly listed as "A." Dr Redberg's full name should read "Rita F. Redberg, MD, MSc."