

## COMMENTARY

# Hospital closures and the current healthcare climate: the future of rural hospitals in the USA

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## ABSTRACT

Hospital closures occur from time to time. These closures affect not only the patients that depend on the hospitals but also the economy in many rural areas. Many factors come into play when a hospital decides to shut off services. Although influencing reasons may vary, hospital closures are likely to be caused by financial shortfalls. In the USA recently, several rural hospitals have closed and many are on the verge of closing. The recent changes in the healthcare industry due to the new reforms are believed to have impacted certain small community and rural hospitals by putting them at risk of closure. In this article, we will discuss some of the highlights of the healthcare reforms and the events that followed, to relate how they may have affected the hospitals. We will also discuss what the future of these hospitals may look like and the necessary steps that the hospitals need to adopt to sustain themselves.

**Key words:** Affordable Care Act, hospital closures, Lean Six Sigma, Medicaid, Medicare, rural hospitals, USA.

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## Context

The USA has witnessed huge reforms and changes in the healthcare industry in recent times. The *Patient Protection & Affordable Care Act* (PPACA) is believed to have changed the landscape of the healthcare system in the country. The federal

government's initiatives to improve the current healthcare scenario is reflected in the revamping of the Medicare and Medicaid insurance programs (programs helping elderly and economically challenged people respectively to be covered with health insurance in order to receive timely care). From 2013 to now, record numbers of people became newly insured due to the expansion with Medicaid<sup>1</sup>. This is not surprising as the programs



are intended to cover 17 million newly insured people. The new health reform also includes initiatives to improve the inpatient quality of care by implementing programs such as the Hospital Readmission Reduction Program (HRRP) and Hospital Value Based Purchasing Program (HVBP).

In sharp contrast to the above events, which imply that the country's overall healthcare scenario is on an upward improving trend, there are some serious concerns that need immediate attention. One important formidable issue is the hospital closures that have happened around the country in recent years. In a country where half of the population are from rural areas, 65 rural hospitals have closed since 2010 and 283 hospitals are on the verge of closing, according to the National Rural Health Association and research from the University of North Carolina<sup>2,3</sup>. Figure 1 illustrates the number of rural hospital closures each year since 2010<sup>2</sup>.

Although the numbers might look small, a closure of hospital in a rural area might have more complications than one would expect. The number of hospitals serving a particular county or a town in rural areas is very low compared to urban areas. When a hospital halts its service, the patients are required to travel very long distances to find the next nearest hospital for care. The situation becomes even worse when the patient has a life-threatening condition. Reports have already surfaced about patients who have died due to long travel distances for care<sup>4,5</sup>. The problems do not stop here when a rural hospital shuts off its services. Hospitals are one of the major revenue yielding business in rural areas as they are often one of the biggest and highest paying employers in those areas. Closure has a domino effect on other local businesses<sup>5</sup>.

## Issues

### *Hospital Value Based Purchasing*

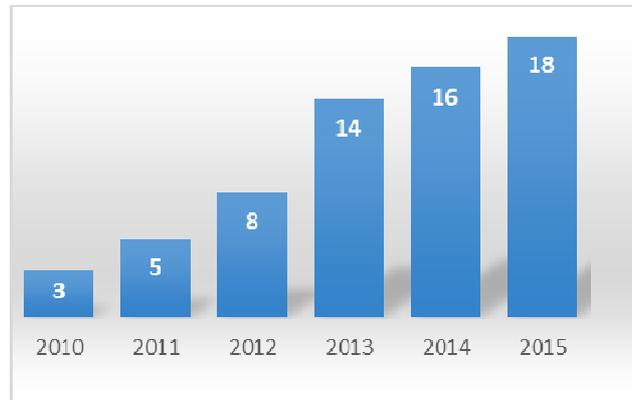
One of the initiatives to tie in quality with reimbursements is the HVBP, which was enacted in Section 3001(a) of the *Affordable Care Act*. HVBP is based on the performances of the hospitals on the hospital quality data reporting infrastructure developed for the Hospital Inpatient Quality Reporting (IQR) Program. The program includes several measures on different domains including

selective processes of care measures (processes of care domain), patient satisfaction surveys (Hospital Consumer Assessment of Healthcare Providers and Systems domain), mortality rates (outcome domain) and Medicare spending per beneficiary (efficiency domain)<sup>6</sup>. Total performance score (TPS) is calculated for hospitals based on their performances on a set of measures from the IQR program. The Centers for Medicare and Medicaid (CMS) fund this program through reduction from participating Hospitals' Diagnosis-Related Group (DRG) payments for the applicable first year. Depending on their TPS, hospitals can earn back an amount that is equal to, greater than or less than the deducted amount. The scheduled DRG deductions commenced in 2013 with 1%, then 1.25% in 2014, 1.5% in 2015, 1.75% in 2016, and reaching 2% in 2017<sup>7</sup>.

### *Hospital readmission penalties and implications*

The other initiative to tie in reimbursements with quality is the HRRP, where the hospitals are penalized for excessive readmissions within a 30-day period<sup>8</sup>. The acceptable readmission rates are based on averages calculated at a national level, and those hospitals that have readmissions higher than the accepted level are penalized up to 3% starting in the 2015 financial year (FY). Launched in 2012, CMS fined hospitals with the maximum penalty of 1% in FY 2013, 2% in FY 2014 and 3% in FY 2015. CMS started HRRP with three measures on health conditions including heart failure, heart attack and pneumonia. Now the measures also include chronic obstructive pulmonary disease and hip/knee replacement conditions. In 2013, 18% of Medicare patients, about 2 million patients, returned to the hospitals within 30 days, with an estimated annual cost of \$26 billion; \$17 billion in unnecessary readmissions could have been avoided<sup>8</sup>.

Despite growing concerns that the Medicare and Medicaid funding pay well below the actual costs of care, the readmission penalties and reimbursement cuts may add a big burden on top of the financial problems that the hospitals are currently experiencing. Rural hospitals are not an exception here because they depend on 45% of the Medicare payments for their total annual income and there are already closures reported due the reimbursement cuts<sup>9</sup>.



Source: American Hospital Association

**Figure 1: US rural hospital closures by year since 2010.**

### ***Reduction in Disproportionate Share Hospital payments***

Many hospitals in poor neighborhoods, which are likely to be used predominantly by the uninsured and poor, are bound to incur uncompensated costs. This eventually becomes a bad debt for the treating hospitals. By law, when a patient enters emergency care, regardless of the patient's ability to pay, the hospital must provide treatment for the patient until they become stabilized or they die. These scenarios incur a debt to hospitals, which are responsible for those costs.

Before the PPACA was in place, the federal government had made some special arrangements to deal with these kinds of situation using the Disproportionate Share Hospital (DSH) program. By this program, funds are allotted to hospitals to cover unmet expenses in order to prevent further financial strain for the treating hospitals. But after PPACA implementation, funds from the DSH program are planned to be reduced on an incremental basis such that it would start receiving cuts from FY 2017 of US\$1.8 billion nationwide and reach US\$4.7 billion for FY 2018–20 and US\$5 billion by 2023<sup>10</sup>. The underlying basis for the reduction of funds is that since Medicaid has been expanded for many new patients along with the PPACA, the previously uninsured people would now be covered by insurance, thereby increasing the

revenue of the hospitals and hence decreasing uncompensated costs. Unfortunately, not all states have accepted the PPACA expansion and some states have declined the federal mandate. States can have respite until the DSH payments are being paid to hospitals, but once it is stopped the condition of hospitals will be even worse.

Along with the DSH payments, hospitals have been historically supported by charity donations in the past. But the health reforms seem to have affected those funding sources as well<sup>11</sup>.

### ***States declining Medicaid***

In spite of the unfavorable events after the PPACA was implemented, some states have already declined the expansion of Medicaid. According to the Whitehouse website, 22 states have declined the expansion of Medicaid, leaving 4.3 million people uninsured. The refusal came only after the Supreme Court in 2012 upheld the constitutionality of the PPACA's mandate of requiring the majority of the people to have minimum health insurance coverage, starting in 2014<sup>12</sup>.

According to a study from RAND Corporation, the cost of expanding Medicaid is lower than the expenses for providing



uncompensated care to uninsured patients<sup>13</sup>. The RAND study also reveals that an estimation of 19 000 deaths would occur annually if the states would not expand Medicaid. Another study from the University of North Carolina reveals that the number of hospitals closed are more in the states that did not expand the Medicaid than the ones that did expand<sup>14</sup>.

## Lessons learned

### *Future of hospitals in the USA*

Although the relationship between the present increasing trend in closure of rural hospitals and the abovementioned facts and events is yet to be explored, we tend to believe that the events may have expedited the closure of already struggling hospitals with reimbursements cuts and other implications of the law.

With a series of events unfolding in the past few years, it is very evident that the quality of care provided by hospitals is scrutinized at a very detailed level. With that being said, hospitals with a good payer mix of private payers and Medicare/Medicaid as well as hospitals that perform well on inpatient quality may escape the effects of changes, now and in the future. On the other hand, the hospitals that depend on government reimbursements for the majority of their revenue and perform poorly on inpatient care may be affected.

### *Remedial actions*

Hospitals need to look for opportunities to reduce costs, improve revenue and profit to have immunity against financial pressures. Strategic-level decisions need to be made by hospital management about improving hospital quality of care, either to introduce new quality improvement initiatives such as Lean Six Sigma or revamp their existing quality improvement programs. Doing so should create a win-win situation for hospitals to improve quality as well as gain revenue by improving utilization rate and patient volume, which has been a longstanding issue for rural hospitals. The

hospitals can attract more patients who usually bypass rural hospitals to get treated in the nearest urban hospitals due to a conception of poor quality of care in rural hospitals. The improvement efforts should also be able to provide immunity to hospitals to some extent against poor socioeconomic conditions in the hospital's vicinity as well as any policy changes in the future that may hamper the existence of these hospitals.

### *Conclusions*

Hospital closure is a serious issue. Several known and unknown factors have been a part of an increasing trend in recent rural hospital closures in the USA. The transition from fee-for-service reimbursements to performance-based reimbursements may have affected the rural hospitals, which are already struggling and are likely to continue to do so with plans for more reimbursement cuts for poor care performance. It is time for the hospitals to overhaul their care processes, in order to stay competitive and care for the needy patients.

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