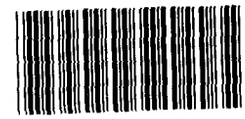
United States General Accounting Office 144765

GAO Testimony



144765

For Release
on Delivery
Expected at
9:30 a.m.
Wednesday
September 4, 1991

**Rural Hospitals:
Closures and Issues of Access**

Statement of Mark V. Nadel
Associate Director for National
and Public Health Issues

Before the
Task Force on Rural Elderly
Select Committee on Aging
House of Representatives

GAO/T-HRD-91-46

GAO Form 160 (12/87)

052311 / 144765

Between 1980 and 1988, there were 200 rural hospital closures. Widespread congressional concern that these closures would jeopardize access to medical care resulted in our issuing three reports on the subject of rural hospital closures.[1] These reports discuss the impact of hospital closures on access to medical care, the factors that increase the risk of closure, and federal, state, and local efforts to address the viability of rural hospitals. In short, the reports concluded that:

-- Although most closures did not significantly reduce access to care, about one-third of the 1986 rural closures may have created or worsened access problems for low-income residents and patients needing emergency care.

-- Rural hospitals were vulnerable to closure since, as a group, they had, more often than urban hospitals, several characteristics associated with the risk of closure.

-- Federal assistance was not well targeted to help rural hospitals whose closure threatened access to care.

---

[1]Rural Hospitals: Federal Leadership and Targeted Programs Needed (GAO/HRD-90-67, June 12, 1990), Rural Hospitals: Factors That Affect Risk of Closure (GAO/HRD-90-134, June 19, 1990), and Rural Hospitals: Federal Efforts should Target Areas Where Closures Would Threaten Access to Care (GAO/HRD-91-41, Feb. 15, 1991). We also discussed rurals in Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991).

The findings in our latest report, dated February 1991, were based on information from national data sources and from 11 case studies of selected hospitals that closed in Illinois, Mississippi, Montana, and Texas.[2] We recommended that the Office of Rural Health Policy within the Department of Health and Human Services (HHS) provide states with guidelines for identifying and monitoring rural hospitals whose closure would make it difficult to obtain essential inpatient or emergency care. We also suggested that the Congress consider using several screening criteria for making financial assistance available to hospitals at risk of closure.

Following is a more detailed summary of our findings and conclusions.

BACKGROUND

Rural hospitals represent one fourth of all acute care beds and about half of all acute care hospitals in the United States. More rural than urban hospitals are small, are government-owned, are in areas with weak economies, and provide care for less complex medical conditions.

---

[2]National data sources included the American Hospital Association (AHA) closure files, AHA Annual Surveys, Medicare Hospital Cost Report Information System, Department of Health and Human Services (HHS') Area Resource File, and HHS Medicare Provider Analysis and Review (MEDPAR-2) file.

The health care environment faced by rural hospitals has changed dramatically in the last decade. The changes include the increasing sophistication and cost of technology used to deliver medical services, the shifting of services from inpatient to outpatient settings, and the establishment of Medicare's fixed-price prospective payment system for inpatient services. These and other changes have contributed to intense hospital competition for a declining number of people who need inpatient care. The changes have also created special problems for small or rural hospitals trying to compete in today's health care market.

A number of interrelated factors affect hospitals' risk of closure. These include small size, low occupancy, and characteristics of the hospital's market, such as competition from other hospitals. These factors and the underlying problems that begin a hospital's financial decline differ for individual hospitals and communities. Low Medicare payment, however, was not among the major factors contributing to the financial distress and ultimate closure of most urban or rural hospitals, although it may have contributed more to the smallest rural hospitals' problems than to those of larger hospitals.

IMPACT OF HOSPITAL CLOSURES ON ACCESS TO MEDICAL CARE

In most areas we studied, closures did not significantly reduce access to inpatient care. Residents of areas serving the closed hospitals had alternative sources of inpatient care that were used by many area Medicare beneficiaries at least 2 years before the closures. Of the 29 communities with a closure in 1986, 21 had at least one remaining hospital within 25 road miles, and all but 2 had at least one alternative hospital within 35 miles.

For the two communities with more distant alternative hospitals, data indicated that Medicare beneficiaries as a group continued to obtain hospital care, since hospital use rates did not drop below the national average in either of the two areas after the closures. However, given the relatively long travel time to the next nearest hospital, we concluded that patients needing emergency care or those without transportation were likely to have been adversely affected by the closures.

Although four other rural 1986 closures were in less remote areas, our data suggested that these closures may have also resulted in access problems for vulnerable populations, including

Medicaid recipients, the uninsured, and those needing emergency care.

Specifically, the data showed greater-than-average declines in the hospitals' use rates between 1984 and 1987. This is consistent with our observation that hospitals sometimes reduce services in the years before closure and that reduced access can therefore manifest itself in a steep decline in utilization over a several-year period rather than in a sharp decline just after closure. The data also showed that the four closures were in medically underserved areas, and in 1984 they treated a much higher-than-average number and proportion of the Medicare patients in their areas. Furthermore, the closures were in poorer counties--those with an average of 28 percent of the population below the poverty rate, compared to an average of 17 percent for all rural areas.

Other observations about the consequences of rural closures concerned the economic impact on communities and the possible rise in Medicare expenditures. We concluded that the closed rural hospitals in our case study had limited economic impact. Because the hospitals had not been large employers, their closures did not cause major economic decline in the communities. In addition, more residents obtained care at more costly

hospitals after the closure, but the growth in expenditures was about comparable to that occurring in areas with no closures.

GOVERNMENT HELP FOR COMMUNITIES AFFECTED BY RURAL HOSPITAL CLOSURES

Of the federal programs that assist rural hospitals, we concluded that the Rural Health Care Transition Grant Program had the most potential to help rural communities with maintaining access to care. Medicare's Sole Community Hospital (SCH) provision and other federal initiatives offering assistance do not appear as likely to sustain the neediest rural hospitals.[3] In the case of the sole community hospitals, for example, which receive favorable Medicare payments, several hospitals whose closure appeared to threaten access to inpatient or emergency care for some residents would not have been identified through SCH criteria. In the case of other federal assistance efforts, several provided financial relief to certain subgroups of rural hospitals, but they did not systematically aim at maintaining access to hospital care.

---

[3]Essential Access Community Hospital Program, Rural Health Clinic Act, Medical Assistance Facility Demonstration, Rural Referral Center Provision, Lugar Provision, National Health Service Corps, Office of Rural Health Policy, Swing Bed Program: These federal efforts are discussed in Rural Hospitals: Federal Leadership and Targeted Programs Needed, GAO/HRD-90-67.

A federal program with more potential, we have concluded, is the Rural Health Care Transition Grant Program, because it has the potential to address a hospital's underlying operational problems. It is designed specifically to help hospitals change their type and mix of services. We also believe, however, that the program's assistance policies need to be strengthened.

For example, at the time of our February 1991 report on rural hospitals, the Health Care Financing Administration (HCFA) had awarded nearly 400 grants, each for up to $50,000 for 3 years, without considering the applicant hospital's financial need, its viability, or the extent to which it provided essential services. Consequently, hospitals that could fund their projects internally were competing equally with financially weak hospitals providing essential services. HCFA was not required to target the grant funding, but it was also not prohibited from doing so.

Similarly, HCFA did not assess whether the grant, together with other proposed funding, would be sufficient to make a hospital at risk of closure financially viable. Our case studies suggested that just before closure, only a major investment could have made a difference for some of the hospitals. In addition, HCFA made the grant awards usually for the maximum amount, indicating that the amounts requested and provided could be based on the funds available rather than the amount needed to make a significant

difference in the hospital's financial status. A more discriminating assessment of a hospital's financial condition, however, could have helped protect the government from providing too little help too late to avoid closure.

Another aspect of the Transition Grant Program that may need to be reconsidered is that only hospitals are eligible to receive grants. Given the tenuous financial condition of some hospitals, we believe that in some communities improving transportation systems or training emergency personnel may be better targets for financial aid to maintain access.

The Essential Access Community Hospital program, which has not been implemented to date, also appears to be a promising federal effort for assisting rural hospitals. The program is designed to offer essential access hospitals a distinct designation and provides new grant money to designated rural hospitals in seven states. It would also establish a new type of facility for rural hospitals whose alternative may be closure. The facilities are called "rural primary care hospitals" and provide 24-hour emergency care and limited inpatient care. This alternative type of limited-service hospitals appears promising because not every rural community has the population base or need for a traditional full-service hospital. In addition, the program would form

"rural health networks" to link rural hospitals through communication systems and patient referral and transfer agreements.

CONCLUSIONS

We believe that HHS should take a more active role in developing and implementing a coordinated approach to identify and assist communities where hospitals provide essential services and are at risk. The issue today is not one of authority for or availability of resources to provide such assistance, because over the years the Congress has given HHS both. Rather, the issue is how HHS uses its authority and resources to direct the right kinds of assistance to the right hospitals. HHS can do more with what it has to help assure rural areas continue to retain their access to essential health care services.

Further, if the Congress decides to take additional actions to assist rural hospitals, it should incorporate three principles that we had previously suggested.[4] Funding should

-- target at-risk, essential, and potentially viable hospitals;

---

[4]Medicare: Further Changes Needed To Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991).

-- be sufficient to make a difference in financial status for these hospitals; and

-- help a community strengthen access to alternative sources of care, if a hospital providing essential services is not likely to remain viable.