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ILLINOIS GOVERNOR SIGNS BILL FUNDING CONVERSION OF UNDERUTILIZED HOSPITALS

Similar Initiatives Emerging Nationwide

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Illinois Gov. Bruce Rauner recently signed legislation that substantially updates the state's hospital assessment program.[1] The program gathers contributions from hospitals to seek matching federal funds, which are then redistributed with a focus toward facilities treating higher volumes of Medicaid patients. Importantly, this legislation also:

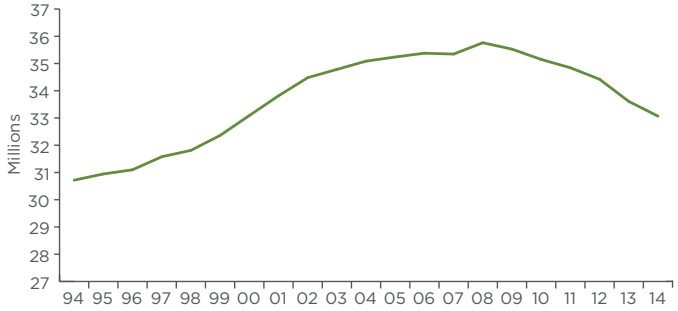
- Provides for $263 million in initial funding[2] that may be used toward renovation and other costs by underutilized or "overbedded" hospitals to fully or partially convert their inpatient beds to other uses.
- Enacts a "Hospital Transformation Review Committee" to establish detailed guidelines over the next several months, including prioritizing projects that adapt facilities to provide behavioral health services, free-standing emergency centers, long-term care, or other unmet needs. The legislation also exempts projects approved by the committee from certain certificate of need program-related reviews.

WHAT'S DRIVING THE DECREASE IN NEED FOR BEDS?

The Illinois legislation begins to address the glut in what has traditionally been the hub of our healthcare infrastructure: inpatient acute-care hospital beds. Medical and technological advancements have driven declining inpatient utilization rates and average length of stay, leading to a decrease in total inpatient days (and thus beds). The trend of services once thought to demand an inpatient stay moving to outpatient settings is likely to accelerate (Figures 1-3), among them minimally invasive total joint replacements and cardiac catheterization.[3]

1. Sarah Zimmerman, "Rauner signs new Medicaid funding plan for hospitals," The State Journal-Register, March 12, 2018.
2. Illinois Senate Bill 1773.
3. Kristin Truesdell, "The FY 2017 Financial Future: How the Cath Lab Impacts the Hospital Bottom Line," Cath Lab Digest, October 2016. https://www.cathlabdigest.com/article/FY-2017-Financial-Future-How-Cath-Lab-Impacts-Hospital-Bottom-Line.

Figure 1: Inpatient Admissions in Community Hospitals, 1994 – 2014



Source: Analysis of American Hospital Association Annual Survey data, 2014, for community hospitals.

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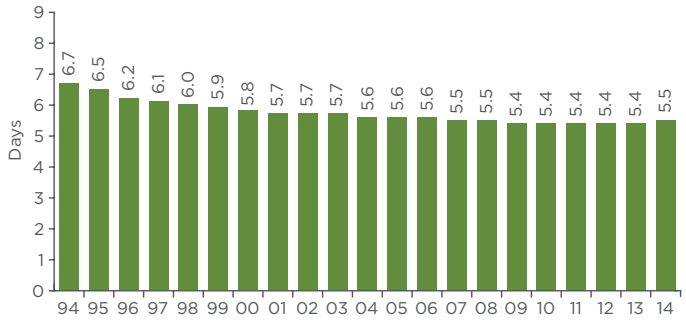
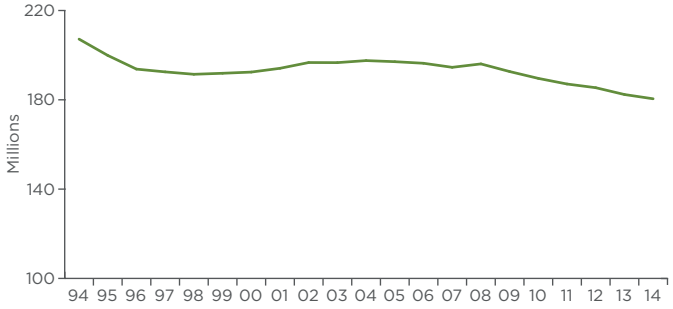
Figure 2: Average Length of Stay in Community Hospitals, 1994 – 2014



Source: Analysis of American Hospital Association Annual Survey data, 2014, for community hospitals.

Figure 3: Total Inpatient Days in Community Hospitals, 1994 – 2014



Source: Analysis of American Hospital Association Annual Survey data, 2014, for community hospitals.

THE CHALLENGE AHEAD FOR HOSPITALS

Our health facility infrastructure, much of it still dating to the Hill-Burton Act era of hospital expansion, is just starting down the path of adapting to the reduced need for beds and broader changes in healthcare delivery. The overcapacity is seen most directly in hospital occupancy rates, which as recently as 1990 averaged close to 70%,[4] a level of occupancy that facilitates an efficient and sustainable use of resources while still providing significant contingency for surges in admissions.

Occupancy rates can vary significantly between urban and rural hospitals and by specific market. In 2014, the nationwide average occupancy rate was 61%, whereas rural hospitals with fewer than 100 beds had an average of 37%. That year, Atlanta had a market wide occupancy rate of 72%, while St. Louis, Missouri was at 55%.[5] Low occupancy rates are not surprisingly correlated with poor operating margin; in a MedPAC study of 28 hospitals that closed, the average occupancy rate was 25% (19% among rural facilities, 32% for urban markets) and the operating margin -5.6%.

WHAT OPTIONS EXIST FOR HEALTH SYSTEM LEADERS?

Of the 28 hospitals described above that closed, eight were reconfigured to provide free-standing emergency departments, urgent care centers, or other outpatient and community-supported developments like healthcare villages. Other hospitals are being transformed to post-acute care or assisted-living facilities, and even general residential uses.[6] For leaders considering these options, a brief market assessment, as well as an initial feasibility study of the infrastructure, is advisable. Many markets may be saturated in these offerings and certain facilities will have significant physical limitations on future use based on irregular floor plans, low floor-to-floor heights, or mechanical and electrical systems.

4. Annual Survey of Hospitals. Hospital Statistics, 1976, 1981, 1991-92, 2002, 2014, 2015, and 2016 editions, American Hospital Association.
5. "March 2016 Report to Congress," Medicare Payment Advisory Commission (MedPAC). http://www.medpac.gov/docs/default-source/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf.
6. Phil Galewitz and Anna Gorman, "More ailing hospitals are being resuscitated as upscale living spaces,, The Washington Post, November 22, 2017. https://www.washingtonpost.com/realestate/more-ailing-hospitals-are-being-resuscitated-as-upscale-living-spaces/2017/11/21/e1af7ec2-b34f-11e7-9e58-e6288544af98_story.html?noredirect=on&utm_term=.7bafa7a5d14d.

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Other factors may also rule out existing campuses from continuing as outpatient-only facilities or with a substantially scaled back inpatient footprint (e.g., microhospitals). Facilities with limited accessibility and visibility from major roadways will be ineffective in attracting patients demanding increasing convenience and retail-like experiences. Extended drive times to larger affiliated community hospitals or regional medical centers will prohibit successful free-standing emergency departments or microhospitals; the aligned "parent" hospitals are needed to accept transfers from these distributed locations, and to facilitate clinical and support services efficiencies such as "e-ICUs" or satellite lab locations.

Health system leaders may not need to face these transformation efforts alone. In addition to the recently passed bill in Illinois, a limited number of other states currently offer or are considering similar initiatives encouraging conversion of inpatient facilities, and proposed legislation suggests similar changes to federal programs. In November 2015, the state of Washington announced $5.5 million in grants to convert underutilized medical-surgical beds to psychiatric units,[7] while Maryland recently passed legislation exempting free-standing facilities from certain certificate of need requirements.[8]

At the federal level, the Rural Emergency Acute Care Hospital (REACH) Act introduced in 2017 (but not passed) would have created a new rural emergency hospital (REH) designation under the Centers for Medicare & Medicaid Services. REHs would provide only 24/7 emergency care, observation care, and outpatient services; the American Hospital Association expressed support for this act.[9]

As these initiatives emerge, health system leaders should remain engaged with their legislative representatives and continue to evaluate if their communities and facilities are candidates for transformation.

7. "State awards $5.5 million to increase number of short-term psychiatric care beds," Washington State Department of Commerce. http://www.commerce.wa.gov/news-releases/community-grants/state-awards-5-5-million-increase-number-short-term-psychiatric-care-beds/.
8. General Assembly of Maryland Freestanding Medical Facilities, Certificate of Need, Rates, & Definition. http://mgaleg.maryland.gov/webmga/frmMain.aspx?id=sb0707&stab=01&pid=billpage&tab=subject3&ys=2016rs.
9. "AHA Expresses Support for the Rural Emergency Acute Care Hospital (REACH) Act, S. 1130," American Hospital Association. https://www.aha.org/letter/2017-05-18-aha-expresses-support-rural-emergency-acute-care-hospital-reach-act-s-1130.

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