Hospital Case Study: Impact of Expanded Healthcare Coverage

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

November 2015

Arkansas has led all states in achieving the greatest percentage reduction in the number of uninsured citizens from 2013 through the first three months of 2015.[1] Compared to surrounding states—where uninsured rates are among the highest in the nation and health statuses are among the lowest[1,2]—Arkansas has been a trailblazer by opting to expand coverage for its low-income adult population by using available Medicaid funding via the Arkansas Health Care Independence Program (HCIP). The HCIP provides newly eligible individuals with premium assistance to purchase qualified health plans through the Arkansas health insurance marketplace.

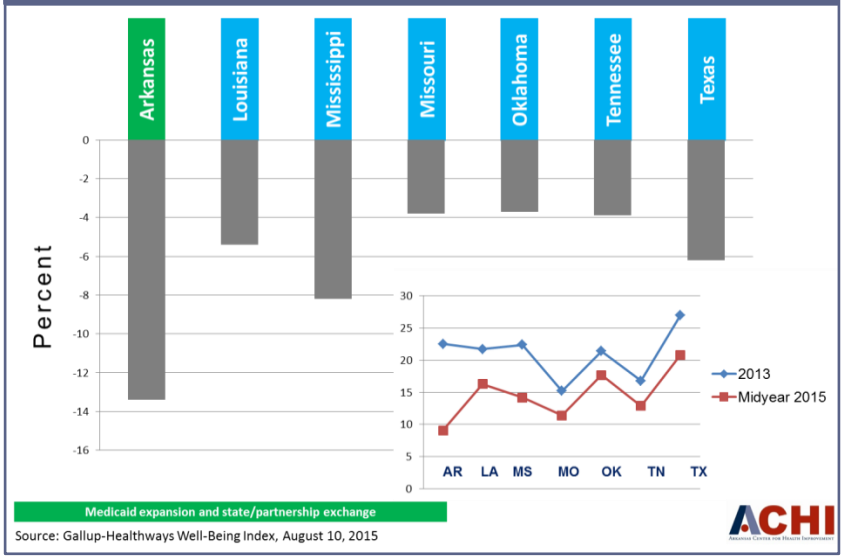
Information provided by the Arkansas Hospital Association (AHA) has shown that reducing the number of uninsured citizens has had a positive impact on the fiscal health of hospitals statewide through a reduction in uncompensated care costs.[3] This is important because hospitals play a vital role in the economic health of our state and local communities. Nationwide, they are a considerable source of private sector jobs and the largest employer in some of Arkansas's rural communities.[4] A typical critical access hospital employs 141 people; generates $6.8 million in wages, salaries, and benefits; has an average annual construction investment of $4.2 million; and has a medical service area population of 14,600.[5] In addition to helping support nearly 10 percent of all non-farm jobs in the state,[6] the close proximity of necessary hospital services significantly influences decisions for industrial and business location.

Arkansas has fared better than many neighboring states in avoiding the closing of rural hospitals (see Figure 2). As a legislative task force considers whether—and if so, how—to continue coverage for HCIP populations, a closer look at the effect the HCIP has had on Arkansas hospitals is warranted. This case study explores the program's impact on hospital systems with facilities both in Arkansas and in surrounding states.

INTRODUCTION

Diverging from the resistance in surrounding states, Arkansas opted to utilize available Medicaid funding under the Patient Protection and Affordable Care Act (ACA)[7] to expand coverage for low-income Arkansans. For purposes of this case study, the Arkansas Center for Health Improvement (ACHI) worked with the Arkansas Hospital Association (AHA) to identify hospital systems with facilities both in Arkansas and in surrounding states. The intent of this examination was to assess the impact of Arkansas's coverage expansion on facilities in the state compared to the impact of the absence of coverage expansion on facilities in surrounding states.

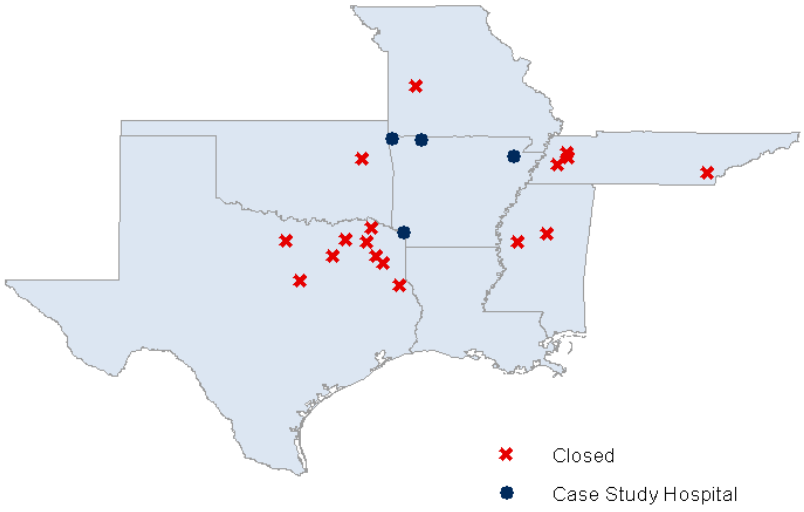
Figure 1: Change in Percentage of Citizens without Health Insurance 2013 vs Midyear 2015



ACHI staff interviewed hospital executives from the identified hospitals and inquired about general information such as service area and populations served but focused on noticeable changes from 2013 to 2014 in uncompensated care, service utilization, and payer mix. Arkansas hospitals identified for the case study included Ozarks Community Hospital in Gravette, NEA Baptist

Memorial Hospital in Jonesboro, and Mercy Hospital in Berryville. Hospital executives from CHRISTUS St. Michael Health System in Texarkana, Texas, were also interviewed due to its unique location on the southwest border of Arkansas and its historic blend of patients served from Arkansas and Texas.

Figure 2: Rural Hospital Closings in Southern States



Source: Adapted from the North Carolina Rural Health Research Program, "56 Rural Hospital Closures Map." Accessed August 2015.

Source Note: A rural hospital is any short-term, general acute-care, non-federal hospital that: a) is not located in a metropolitan county; b) is located in a rural-urban commuting area (RUCA) type 4 (large urban cluster)[8] or higher; or c) is a Critical Access Hospital.

Note: Crittenden Regional Hospital in West Memphis, which was not considered a critical access hospital, closed in September 2014. Reasons cited by the hospital's board for the closure were a struggling economy, significant declines in patient volume and reimbursement over the last decade, recent physician departures and two fires, including one that shut down the facility for six weeks.

FINDINGS

Arkansas hospitals in the study reported an overall positive financial impact from coverage expansion through the HCIP. Arkansas hospitals further reported that the impact from the HCIP was bolstered by individuals gaining subsidized coverage through the Arkansas health insurance marketplace. Hospitals reported that in Arkansas, coverage expansion mitigated the blow of Medicare cuts imposed by the ACA by reducing uncompensated care and, to a lesser extent, increasing care utilization among individuals with a payment source. ACHI engaged in this examination in part due to reports of additional hospital investments in personnel or service lines, provider migration from surrounding states to Arkansas, and the shifting of resources from hospitals in surrounding states to Arkansas—experiences that varied among the hospitals examined. Interviews revealed patterns among the hospitals with respect to shifts in self-pay to private and Medicaid payment sources and reductions in uncompensated emergency department (ED) visits and inpatient stays. Hospitals also reported that while the volume of ED visits remained steady or slightly increased, the volume of patients presenting with lower levels of acuity decreased. This suggests movement toward more effective use of primary care.

Caption: The OCH Gravette Hospital

Ozarks Community Hospital Healthcare System

Ozarks Community Hospital (OCH) Chief Executive Officer (CEO) Paul Taylor offered the starkest example of the impact of coverage expansion in Arkansas when compared to the absence of expansion in Missouri. OCH healthcare system is comprised of two hospitals and 18 clinics located in northwest Arkansas and southwest Missouri. The OCH system had 220,000 primary care visits during the past 12-month period, serving 42,000 patients. OCH Gravette, Arkansas, hospital has 25 beds and serves a largely rural population that extends beyond the Arkansas border into Missouri and Oklahoma. The facility itself is the formerly shuttered Gravette Medical Center Hospital Building, which OCH reopened in 2008. OCH Springfield, Missouri, hospital is a comparable hospital in size staffed for 25 beds but serves a largely urban population in the Springfield area.

At the Springfield hospital, services have been significantly reduced over the past 18 months. Medical and behavioral-health inpatient services have been virtually eliminated, and inpatient surgeries have been limited to one day per week. This has resulted in staff reductions of 97 full-time employees and a reduction in average daily census to less than one. In contrast, during the same period, the Gravette hospital has increased all ancillary and specialty care services and developed a niche as a regional wound care center. As a result, 198 full-time employees have been hired, mostly registered nurses earning between $60,000 and $70,000 per year. The hospital is now the largest employer in Gravette, a community with a total population of about 2,000.

According to Taylor, growth of the OCH in Gravette has had other implications for the community, including attracting a family practice physician from Missouri who plans to open a practice at the clinic next door to the hospital, a new strip mall with several restaurants near the hospital, and a new Walmart Express with a pharmacy.

Taylor sees the coverage expansion in Arkansas as an economic engine, saying, “What would we do to attract an industry or business that will hire 200 people earning an average of more than $20 per hour?”

Like other Arkansas hospital officials interviewed, Taylor reported little change in the volume of ED visits and inpatient stays, although the Gravette hospital saw large reductions in the volume of ED visits and stays that were self-pay.

Mercy Health System

Mercy Health System (Mercy) includes 29 acute-care hospitals and over 300 clinics and outpatient facilities in Arkansas, Kansas, Missouri, and Oklahoma. This case study focused on Mercy’s Berryville, Arkansas, critical access hospital compared to Mercy’s southern Missouri hospitals in Cassville and Aurora, which are similar in size to the Berryville location. The Berryville hospital is a 25-bed facility, while the Cassville and Aurora facilities have 18 and 25 beds, respectively.

Like other hospitals around the nation, Mercy hospitals are streamlining delivery of care and administration in response to reductions in Medicare reimbursement and federal and state programs designed with outcome-based payment structures. Mercy recently reduced the number of staff across its health system by approximately 300, with a handful of those being in Arkansas. This comes at a time when Mercy has expanded its presence in northwest Arkansas by opening clinics in Bentonville, Centerton, Rogers, and Bella Vista.

While the HCIP in Arkansas did not immunize the Berryville hospital from system-wide reductions in staff, it has mitigated the financial strain of Medicare cuts on the Berryville facility. Mercy has estimated that the HCIP may have a positive financial impact on the Berryville hospital of $450,000 annually. This estimate is based on a 33 percent reduction in self-pay patients from 2013 to 2014, while the Aurora and Cassville hospitals saw reductions of 11 and 6 percent, respectively.

CHRISTUS St. Michael Health System

CHRISTUS St. Michael Health System (CHRISTUS) serves populations from Arkansas, Texas, and Oklahoma at its two hospital sites in Texas in Texarkana and Atlanta. This case study focused on the Texarkana hospital due to its location on the Arkansas-Texas border. The Texarkana acute-care hospital is a 312-bed facility that has historically provided $19 million in charity care annually. Notably, CHRISTUS officials indicated that in addition to increased volume at their Texarkana facility they have also seen increased volume at their Atlanta, Texas, location due to the closure of the only other hospital in the county.

Caption: The CHRISTUS St. Michael Health System

CHRISTUS reports that while ED use at their Texarkana facility increased overall by nearly 5 percent, the volume of

low-level acute visits to the ED—particularly among those with subsidized and HCIP coverage—was decreasing. CHRISTUS officials indicated that patients are slowly beginning to access primary care services and are utilizing the ED for more appropriate, higher-level acute needs.

Baptist Memorial Health Care

The Baptist Memorial Health Care (Baptist) system has 14 hospitals throughout the mid-south in Arkansas, Tennessee, and Mississippi. The NEA (Northeast Arkansas) Baptist Memorial Hospital facility in Jonesboro, Arkansas, has 192 acute-care beds integrated with a multi-specialty clinic. The newly constructed Jonesboro facility opened in January 2014 and has seen increased volume in inpatient stays, ED visits, and outpatient visits from 2013 to 2014. The number of self-pay patients has decreased by 18 percent over the same period. Baptist officials noted the marked increase in non-ED outpatient visits—which nearly doubled from 2013 to 2014—as a sign that patients are increasingly seeking services in more appropriate venues, which will ultimately help them to avoid ED visits. Baptist has located a wholly owned urgent care clinic across the street from the hospital facility so that patients have another option for needs that are less than acute.

Baptist officials indicated staff reductions in all hospitals in Mississippi and Tennessee from 2013 to 2015 except for its women's hospital just across the Arkansas border in Memphis. At the same time, the Jonesboro facility increased staff by 250—a nearly 40 percent increase.

CONCLUSION

Expanded healthcare coverage for low-income populations in Arkansas has been critical to the viability of hospitals that serve Arkansans at all income levels. In some cases, expanded coverage has been a lifeline—particularly in rural areas—allowing for an increase in services. This is in stark contrast to closures experienced by similarly situated counterparts across the state's borders. In other instances, expanded coverage has provided a financial buffer, enabling hospital leadership to streamline operations in preparation for migration to value-based systems that reward better outcomes rather than volume of services provided. As coverage expansion in Arkansas matures, continuing investment in patient education will be key to ensuring appropriate and timely use of hospital services and reducing unnecessary use of EDs. Thus far, Arkansas hospitals appear to be well positioned to respond to a changing landscape and to continue to be major employers and economic drivers in their local communities.

REFERENCES

[1] Writters D. "In U.S., Uninsured Rates Continue to Drop in Most States." *Gallup-Healthways Well-Being Index*, August 10, 2015; http://www.gallup.com/poll/184514/uninsured-rates-continue-drop-states.aspx.

[2] "America's Health Rankings: A Call to Action for Individuals and Their Communities - 25th Anniversary Edition 2014." *United Health Foundation*, December 7, 2014; http://cdnfiles.americashealthrankings.org/SiteFiles/Reports/Americas%20Health%20Rankings%202014%20Edition.pdf.

[3] "Arkansas Private Option: Benefit to Arkansas Hospitals January 1 – December 31, 2014." *Arkansas Hospital Association*, July 2015; Accessed at http://www.arkhospitals.org/Misc.%20Files/APO7-9-15.pdf.

[4] "Reports: Comprehensive Arkansas Data: Major Employers by County." *Arkansas Economic Development Commission*; Accessed at http://www.arkansasedc.com/data/reports in October 2015.

[5] Doeksen G, St. Clair CF, Eilrich FC; for the National Center for Rural Health Works. "The Economic Impact of a Critical Access Hospital on a Rural Community." [Research Study] *National Center for Rural Health Works*, September 2012; http://ruralhealthworks.org/wp-content/files/Impact-of-CAH-Study-NEW-FORMAT-090712.pdf.

[6] Arkansas Hospital Association. "Arkansas Hospitals: Numbers tell the Story." *Arkansas Hospitals*, Summer 2015; http://www.arkhospitals.org/archive/arkhospmagpdf/2015Stats/KeyNumbersBehindImportantFacts.pdf.

[7] Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 et seq. (2010).

[8] "2010 Rural-Urban Commuting Area (RUCA) Codes." Washington, DC: *United States Department of Agriculture Economic Research Services*; Accessed at http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/documentation.aspx in November 2015.