A Case-Study Investigation of Charity Care and Essential Service Provision Following Hospital Conversion to For-Profit Status

by

Deborah J. Chollet, Ph.D.
and
Adele M. Kirk, M.H.A.

Alpha Center
Washington, DC

The Public Policy Institute, formed in 1985, is part of the Research Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of interest to older Americans. This paper represents part of that effort.

The views expressed herein are for information, debate, and discussion, and do not necessarily represent formal policies of AARP.

©AARP.
Reprinting with permission only.
AARP, 601 E Street N.W., Washington, DC 20049
Acknowledgments

Several people contributed to this report. The authors express their appreciation to Rachel Ermann of the Alpha Center, for her capable research assistance, and also to Carol Lee for her editorial contributions. We thank Fish Brown and Phillip Isenberg for reviewing the paper and providing valuable suggestions, and hospital and community sources for sharing important perspectives. We thank AARP staff who played an important role in this project, especially Jo Ann Lamphere as well as John Luehrs, Amanda McCloskey, and Gerry Smolka. Finally, we thank Jack Needleman for his valuable contributions.
Foreword

Conversion of not-for-profit and public hospitals to for-profit ownership in many states during the past fifteen years has sparked controversy among policy-makers, community advocates, and health services researchers about the implications of these conversions for access to care. Despite increasing public scrutiny of these conversions in some areas, information is limited about their effect on individuals’ access to health care in different communities and the role of state oversight in protecting essential health services.

This research project was designed to help public policy-makers, consumer activists, and others understand the impact of hospital conversions on the provision of health care in many communities. In carrying out this study, we did not assume that hospital conversions are a positive or negative development in the health care sector. Instead, we assumed state and local officials want to manage fairly the terms of hospital conversions, without undue incentives or impediments, while, at the same time, protecting the availability of health care in affected communities.

This study reinforces the importance of ongoing public scrutiny during and subsequent to a hospital’s conversion.

Jo Ann Lamphere, DrPH
Senior Policy Advisor
Public Policy Institute
## CONTENTS

**EXECUTIVE SUMMARY** ................................................................. vi

**INTRODUCTION** ........................................................................... 1

**SECTION ONE:**
**LITERATURE REVIEW** ............................................................... 1
  - Corporate finance and operational efficiency ........................................ 1
  - Charity care .................................................................................. 3
  - Essential services .......................................................................... 6
  - Community benefit ........................................................................ 6

**SECTION TWO:**
**STUDY METHODS** ..................................................................... 7
  - Selection of hospitals ..................................................................... 7
  - Unpublished sources of information ............................................... 8
  - Published sources of information .................................................. 10

**SECTION THREE:**
**OVERVIEW OF THE CASE STUDY HOSPITALS** ......................... 10
  - Characteristics of the case-study hospitals’ communities ............... 10
  - Characteristics of the case-study hospitals .................................. 11

**SECTION FOUR:**
**DELIVERY OF CHARITY CARE** .................................................. 12

**SECTION FIVE:**
**PROVISION OF ESSENTIAL SERVICES** ....................................... 16

**SECTION SIX:**
**IMPLICATIONS FOR STATE OVERSIGHT** ................................. 18

**SECTION SEVEN:**
**CONCLUSIONS AND FUTURE DIRECTIONS** ............................. 21

**REFERENCES** ............................................................................. 24

**APPENDIX 1:**
**STUDY HOSPITAL PROFILES** ...................................................... 27

**APPENDIX 2:** **CORPORATE HISTORIES** ................................. 36
List of Tables

Table 1: Original Ownership of Study Hospitals and Subsequent Merger or Acquisition Activity Within Five Years of Initial Conversion ................................................................. 9

Table 2: Demographic and Economic Characteristics of the Case-Study Hospital Service Areas ...................................................................................................................... 11

Table 3: Selected Operating Characteristics of Study Hospitals, 1996 ......................................................... 12

Table 4: Medicare and Medicaid Discharges and Uncompensated Care Estimates: Case-Study and Comparison Hospitals, 1996 ............................................................... 14

Table 5: Hospital Sale and Conversion Requirements in 14 States .............................................................. 21
Executive Summary

**Background.** Dramatic changes in the financial and legal structure of hospitals have occurred during the past 15 years, particularly as a result of hospital conversion to for-profit ownership. Not-for-profit hospitals traditionally have pursued missions that include providing care for the medically indigent and supporting the availability of certain health services, sometimes despite their unprofitability. Not-for-profit hospitals, commissioned to operate in the community interest, have converted to for-profit ownership at an unprecedented rate in a trend that has been described by some as the "largest potential redeployment of charitable assets in this nation's history."\(^1\) Given the pace and scale of change, it is understandable that many questions have emerged about the impact of this trend on health care delivery. There has been little available guidance to help policy-makers, regulators, hospital leaders, and community activists consider the effect of hospital conversions.

**Purpose.** This study was undertaken to gain insights about hospital decision-making and community relationships with regard to the delivery of charity care and essential services subsequent to conversion to for-profit ownership. The paper includes a review of relevant health policy and economics literature in order to provide readers with a fundamental understanding of hospital financial behavior, the provision of charity care and essential services, and the meaning of community benefit.

**Methodology.** This study examined the circumstances and corporate histories of seven hospitals throughout the United States that converted to for-profit ownership between 1983 and 1994. Hospitals included in this study were randomly selected from seven strata of ownership categories. Ownership was identified from annual hospital reports to the American Hospital Association. Using a case-study method, information was obtained through a series of detailed, semistructured telephone interviews with hospital administrators and community representatives. (Persons interviewed were chosen because they were familiar with the history of the hospital’s conversion.) The strength of the case study as a research method – and the strength of this study – lies in its context and detail, which are lost in large, representative databases. Information from interviews was augmented with both published and unpublished data.

**Findings.** The hospitals included in this case study varied in their size, occupancy, and case-mix severity. Nearly all of the hospitals that were studied had converted ownership before state laws governing such transactions were passed. Therefore, hospital management priorities, rather than contractual agreements with government jurisdictions, have directed the seven hospitals in their delivery of charity care and essential services after conversion. Few, if any, of the hospitals had been considered major providers of uncompensated care pre-conversion, and only one hospital is now actively engaged in delivering charity care post-conversion. The other hospitals — even one that was a sole community provider — were parts of community arrangements that did not legally oblige them to provide uncompensated care.

In many of the hospitals that we studied, conversion of ownership prompted a critical

review of service capacity. With regard to services considered essential to the community, all hospitals studied maintained their emergency rooms following conversion. Each of the hospitals with trauma centers or obstetrical services continued to provide them after conversion; one hospital discontinued its obstetrical services a few years post-conversion. Other services, such as adult and adolescent inpatient psychiatric services, intensive care, and cardiac services, were discontinued in several hospitals post-conversion. It appears that new hospital ownership reviews a variety of medical services, usually because of patient mix, physician staffing, and liability concerns, to determine whether or not such services should continue. At the same time, the scope of some medical services expanded after the hospital converted to for-profit ownership. Because this study is based on examination of relatively few cases, the conclusions may not necessarily be generalized to all hospitals.

Hospitals that become for-profit entities seem to enter a management environment that is substantially less stable than before conversion. Management changes may occur frequently, either because of changes in the firm’s corporate culture or because the hospital is resold to a succession of new owners.

Implications. This study raises questions about the degree to which communities depending on converted hospitals can expect medical services to remain available in the same manner as in the past. Instability of hospital ownership forebodes uneasiness among those who value the security and continued delivery of a variety of hospital services in their community. These case-study findings suggest that the impetus for hospital service modifications comes from management changes that typically follow hospital conversions. Management concerns related to low service volume or quality and availability of appropriate staff may drive service changes, as may concerns about “breaking even” on a particular service. In sum, changes occurring in converting hospitals’ delivery of charity care and essential services seem driven primarily by individual hospital resources and management concerns, rather than changes in hospital mission or as a response to needs of the surrounding community.

Results of this study also raise questions about whether for-profit and not-for-profit status is any longer a meaningful distinction in predicting hospital behavior as complex ownership and management arrangements among hospitals have become more common. The emergence of not-for-profit holding companies and for-profit management leasing are examples of these arrangements.
Introduction

As large numbers of not-for-profit and public hospitals convert to for-profit status, concerns about charity care and essential health care services have grown. Not-for-profit hospitals typically have pursued missions that include providing care for the medically indigent and supporting the availability of certain health services, sometimes despite their unprofitability. In order to gain insights about whether the conversion trend has affected the availability of charity care or essential services, this report describes the circumstances and corporate histories of seven hospitals that converted to for-profit status between 1983 and 1994. It examines the context of these conversions in an attempt to reconcile the many inconsistencies found in past industry-wide studies about for-profit hospital behavior. In addition, it offers policy-makers and consumers the perspective of other communities’ experience as they consider the future of for-profit hospitals and the communities that they serve.

The study is organized in seven sections. Section One provides an overview of the economic and health policy literature that analyzes for-profit and not-for-profit hospitals’ ownership and management incentives, their delivery of charity care and essential services, and community benefit. Section Two describes the methods used to select hospitals for case studies and obtain information about them. Section Three describes the seven hospitals selected, identifying their characteristics and the nature of the communities that they serve. (Detailed individual case studies are provided in Appendix 1.) Sections Four and Five describe the case-study hospitals’ relationships with communities in which they are located with respect to the delivery of charity care and essential services. Section Six suggests opportunities for public oversight of hospital conversions. Finally, Section Seven offers conclusions about the case-study hospitals as a group and highlights avenues for further investigation for health policy-makers and interested consumers.

SECTION ONE: LITERATURE REVIEW

Health services research has addressed many of the characteristics of for-profit hospital conversions and operations that this study explores, including the following: (1) hospital behavior related to corporate finance and incentives to improve operational efficiency; (2) provision of charity care; (3) provision of essential services; and (4) the reallocation of community benefit. This section reviews the economics and health policy literature in each of these areas.

Corporate finance and operational efficiency

A small but growing literature explores the for-profit status of hospitals as an organizational choice made in the context of a highly competitive health care marketplace where hospitals increasingly bargain for contracts with large employer plans and managed care plans. In this marketplace, health plans (rather than individual admitting physicians) determine each hospital’s patient volume. As economic organizations, hospitals seek more market share in order
to bargain to greater advantage with purchasing organizations. Hospitals choose between non-profit and for-profit status based on the relative availability of debt and equity capital to finance growth. Once a hospital becomes for-profit, equity financing then may drive operational changes.

Gabay and Wolfe (1996) attributed much of the mid-1990s “merger mania” to growing hospital competition for “paying” (i.e., privately insured) patients in the form of managed care contracts. Hospitals increased their demand for new capital to acquire or to maintain market size. Typically, converting or merging hospitals have been seeking capital to upgrade facilities, to purchase new medical equipment, and to improve their information systems in order to compete more effectively (Project Hope, 1997).

Among for-profit hospital corporations, the need to demonstrate earnings growth also may underlie purchaser-initiated hospital acquisitions and mergers. In equity markets, organizations that are able to establish a history of earnings growth can obtain capital more cheaply than organizations with lackluster earnings growth. Gray (1997) argued convincingly that a history of earnings growth can be created by mergers and acquisitions more readily than by improving performance. Thus, for-profit hospital corporations may acquire independent hospitals (sometimes with no significant cash outlay, for example, in the form of a long-term management contract) or merge with another hospital corporation principally to post higher corporate earnings growth.

Conversely, failure to deliver high earnings may underlie for-profit hospital divestitures. Comparing divested and non-divested hospitals of Hospital Corporation of America (HCA) and American Medical International (AMI), McCue and Clement (1992) concluded that divested hospitals were more likely to have lower occupancy rates and less revenue growth.

Finally, concern about earnings growth may drive changes in hospital operations. For example, for-profit hospitals may increase billing and collection rates and cut operating costs in

---

2 In a multi-state study, Gabay and Wolfe found that 15 percent of nonprofit and public hospitals involved in mergers had converted or were in the process of converting to for-profit status as a result of the merger. These types of merger/conversions were most numerous in California (8 hospitals converted to for-profit status out of 11 hospitals forming mergers, acquisitions, or joint ventures) and South Carolina (7 out of 10 such hospitals).

3 Divested hospitals also typically had higher debt-to-asset positions and fewer beds, and were located in market areas with less elderly population growth and less growth in per capita income. Some of these factors, however, may be intertwined. Investigating the factors that influenced high and low profitability among 169 general acute care Florida hospitals in FY1989, Vogel et al. (1993) found that highly leveraged hospitals also were likely to have very low profit margins.

4 Other factors may also drive for-profit hospital divestitures. Evaluating the pre-merger characteristics of Columbia and HCA’s hospitals, McCue (1996) noted the companies’ highly leveraged debt positions may have forced them to divert their cash payments toward interest and principal, rather than financing future replacement and expansion needs to support new services. In a study of HCA hospitals’ performance over two years and Healthtrust hospitals’ performance over four years, Clement and McCue (1996) concluded that these systems’ history of leveraged buyouts ultimately led to the sale of hospitals and subsidiaries but had no discernible impact on the purchased hospitals’ revenues, expenses, or profitability.
order to achieve earnings growth. Various studies support the assumption that for-profit hospital ownership leads to greater operational efficiencies; however, the literature is inconsistent. For example:

- Examining the financial performance of independent nonprofit hospitals between 1978 and 1982 in ten Southern states, Lynch et al. (1990) concluded that for-profit multi-hospital systems helped to solve many of the financial and operating problems of acquired facilities. Relative to not-for-profit hospitals, acquired hospitals had improved access to long-term debt, plant and equipment, profitability (as prices rose more than those in independent hospitals), and efficiency. Acquired hospitals also decreased their liquidity to a greater extent than independents. Comparing 50 for-profit and 60 not-for-profit hospitals in Florida at one point in time (instead of the same hospitals over time), Sear (1991) reached a similar conclusion: investor-owned hospitals used fewer FTE staff per bed and fewer labor hours per case-mix-adjusted patient day, paid lower total wages, and maintained higher operating margins than nonprofit institutions.

- Based on case studies of ten hospitals and analysis of the Medicare cost reports of all hospitals converting to for-profit status in 1995, Project HOPE researchers (1997) concluded that most converting hospitals were in financial distress (either losing money or reporting profit margins significantly below the industry average) in the years preceding conversion, and that the average financial performance of converting hospitals typically improved following conversion. Improved financial performance was achieved in various ways: by decreasing Medicare costs per discharge, by raising prices, and by reducing staff ratios to the industry average.

- Clement and McCue (1996) found, however, that hospitals acquired by HCA and by Healthtrust between 1986/1987 or 1988/1989 and 1990/1991 neither increased revenues, decreased wages or other operating expenses, nor improved profitability relative to other hospitals in their local markets.

**Charity care**

Much of the concern about not-for-profit and public hospital conversions is based on the belief that for-profit hospitals are more likely to reduce the delivery of charity care in favor of services that yield positive revenue margins. This concern is heightened by a coincidence of circumstances related to hospital conversions: most hospitals that convert to for-profit are in financial distress at the time they convert, and important providers of charity care are more likely to experience financial distress than other hospitals.\(^5\)

\(^5\)In an early study of hospitals’ financial status, Hadley and Feder (1983) found that as many as 24 percent of not-for-profit hospitals in 1980 were in financial distress. In financially stressed hospitals, charity care and bad debt represented 13.5 percent of total charges, compared to 5.8 percent of total charges among financially sound hospitals. In a more recent study of not-for-profit hospitals in five states, GAO (1990) similarly concluded that nonprofit hospitals with lower uncompensated care burdens also enjoyed higher operating margins, as did Vogel et al. (1993) in a study investigating the factors that influenced high and low profitability among 169 general acute care Florida hospitals in FY1989.
Very few studies directly investigate whether hospitals that convert to for-profit subsequently change their delivery of uncompensated care. Instead, most researchers have considered cross-sectional data in order to draw inferences about how hospitals’ provision of indigent care might change following conversion. This research has produced conflicting results:

- Using national data from the U.S. Office of Civil Rights (for 1981) and the American Hospital Association (for 1980-1984), Rowland (1981) concluded that for-profit and not-for-profit hospitals delivered comparable percentages of care to Medicaid patients, but that for-profit hospitals provided less care to the uninsured.

- Analyzing hospitals’ Medicare cost reports, Sloan et al. (1988) concluded that only flagship teaching hospitals provided significantly more care to self-pay patients (a proxy measure of uncompensated care) compared to other hospitals, either not-for-profit or investor-owned.\(^6\)

- Lewin et al. (1988) found that not-for-profit hospitals in 1984 and 1985 had uncompensated care burdens that were 50 to 90 percent higher than for-profit hospitals in Florida, Virginia, and North Carolina, and about 14 percent higher in California. In Tennessee, not-for-profit hospitals’ uncompensated care burdens were more than double those of for-profit hospitals.

- Considering a representative cross-section of hospitals in 1991, Norton and Staiger (1994) concluded that, when located in the same area, for-profit and not-for-profit hospitals serve an equivalent number of uninsured patients, but for-profit hospitals are more likely to be located in better-insured markets.

- Analyzing the National Hospital Discharge Survey data from 1979 to 1984, Frank et al. (1990) concluded that for-profit hospitals’ uninsured and Medicaid discharges are significantly lower than those of not-for-profit hospitals, and especially low relative to public hospitals.\(^7\)

The meager literature using time-series data to evaluate post-conversion changes in the delivery of uncompensated care within a consistent set of hospitals is also conflicting:

- A 1993 study by the U.S. General Accounting Office (GAO) suggested that for-profit and not-for-profit hospitals may both use strategies to avoid systematic sources of

---

\(^6\)Several earlier studies comparing individual hospitals or hospital chains (Herzlinger and Krasker, 1987; Pattison and Katz, 1983; and Sloan and Vraciu, 1983) reached a similar conclusion – that the Medicaid and/or uncompensated care burdens of not-for-profit and for-profit hospitals are similar; however, none of these studies was based on a nationally representative sample of hospitals.

\(^7\)Uninsured patients also have shorter (case-mix adjusted) lengths of stay than insured patients in all hospital types. In for-profit hospitals, actual lengths of stay for uninsured patients were lowest relative to expected length of stay, and especially low relative to church-affiliated not-for-profit hospitals. For-profit hospitals also have both lower Medicaid caseloads and shorter actual lengths of stay for Medicaid patients relative to expected caseloads and lengths of stay, compared to other hospital types.
uncompensated care. (Such sources may include, for example, emergency room services and obstetrics). Responding to concern that for-profit hospitals may be establishing for-profit joint-venture arrangements (often with outpatient diagnostic imaging centers, outpatient surgical centers, and primary care clinics) that reduce indigent patients’ access to care, the GAO reviewed 23 of these joint ventures. It concluded that (1) hospitals’ joint venture contracts in fact served very few poor patients;\(^8\) (2) the rate of joint ventures was similar between for-profit hospitals (20 percent) and not-for-profit hospitals (18 percent); and (3) for both hospital types, the rate declined toward 1991.

- Evaluating the pre-merger characteristics of Columbia and HCA’s hospitals, McCue (1996) concluded that both systems’ hospitals had fewer Medicaid patients, lower proportions of outpatient revenues, and higher operating cash flow per bed relative to local competitors\(^9\) – suggesting that systematic differences between not-for-profit and for-profit hospitals’ delivery of uncompensated care may reflect systematic differences prior to conversion, not changed practice following conversion.

- A recent study of converting hospitals’ behavior over time corroborates this perspective: Young et al. (1997) concluded that California hospitals that converted to for-profit status did not reduce their delivery of uncompensated care, but these hospitals provided less uncompensated care before conversion.

Other time-series research suggests that the likelihood that hospitals will deliver uncompensated care is a complex consideration and cannot be studied with such simple models. Banks et al. (1997) hypothesized that for-profit hospitals balance incentives to maximize short-run margins with potential, long-run gains from heeding community expectations about charity care. Specifically, in periods and markets where the demand for inpatient days is falling (due to growing managed care), for-profit hospitals’ marginal (opportunity) cost of providing charity care is less. Under these circumstances, for-profit hospitals are more likely to increase their delivery of uncompensated care. In contrast, not-for-profit hospitals gauge their ability to deliver charity care on their level of net revenues. Thus, when the demand for inpatient care (and net revenue) declines, not-for-profit hospitals reduce delivery of charity care. Using a pooled time-series cross section of nonpublic California hospitals between 1981 and 1989, Banks et al. found significant relationships consistent with this view of hospital behavior.

At least one earlier study also supports the finding that for-profit hospitals provide greater levels of charity care when the marginal cost is lower. Examining uncompensated care before and after the start of Medicare prospective payment, Hultman (1991) found an overall increase in uncompensated care between 1983 and 1985 in all sectors, but investor-owned hospitals increased delivery of uncompensated care more rapidly than nonprofit hospitals did.

---

\(^8\)Medicaid revenues and uncompensated care together averaged just 2.8 percent of total revenues.

\(^9\)Pre-merger, these hospitals also had lower occupancy rates and lower salary expenses per discharge than local competitors, despite also having fewer beds, a higher case-mix index, and higher debt-to-total assets.
Essential services

One way that hospitals can reduce the uncompensated care they provide is to alter their mix of services, terminating services that draw relatively high rates of underinsured or uninsured patients and expanding services that draw patients who are likely to be fully insured. The services believed to generate the most uncompensated care (including both charity care and bad debt) have been obstetric services and emergency services, such as trauma care.

Both Townsend (1986) and Sloan et al. (1988) concluded that obstetric services accounted for a disproportionate share of uninsured admissions. However, these results may have been sensitive to both time and place. In a later study of Georgia hospitals between 1990 and 1992, Chollet (1993) concluded that obstetric discharges were negatively related to the hospitals’ uncompensated care burdens and contributed substantially (and positively) to their revenue margins.

We were unable to find any research that investigates specifically whether for-profit hospitals are less likely than not-for-profit hospitals to offer services that are likely points of entry for Medicaid and uninsured patients. There is some evidence, however, that such services are generally at risk. Reviewing hospitals in six cities, GAO (1991) found that one-third of the trauma centers had stopped providing trauma care to severely injured people during the prior five years, primarily due to financial losses associated with serving Medicaid (or other public program) patients. Thus, concern that for-profit hospitals are more likely to terminate trauma centers or other emergency care services is based only on the belief that for-profit hospitals respond faster than not-for-profit hospitals to negative revenue margins.

Community benefit

A growing literature examines hospitals’ delivery of charity care and essential services as specific examples of hospitals’ broader commitment to providing community benefit. Community benefit may include not only the delivery of charity care and unprofitable but essential services, but also the range of “community oriented” services they provide and greater involvement in professional education (Arrington and Haddock, 1990). More controversial components of community benefit include: (1) for-profit hospitals’ tax payments, and (2) not-for-profit hospitals’ characteristically lower charge-to-cost ratios.

Distribution of community benefit. A recent review of the literature (Claxton et al., 1997) concluded that not-for-profit hospitals typically do provide more community benefit than for-profit hospitals, especially in the form of uncompensated care, involvement in teaching and research, and losses from public programs (the excess of cost over reimbursement from Medicaid or Medicare). However, nonprofit hospitals vary widely in their provision of community benefit. Public hospitals and major teaching hospitals provide a large proportion of the community benefit

---

10As suggested by an Institute of Medicine study (Gray, 1986), Arrington and Haddock (1990) developed a community services index that included family planning, emergency department, health promotion, outpatient department, social work, patient representative, and volunteer services.
associated with not-for-profit hospitals as a group, and a significant number of nonprofit community hospitals provide very little community benefit.

**Taxes paid as community benefit.** When payment of federal, state, and local taxes are included in the calculation of community benefit, for-profit hospitals can compare favorably to not-for-profit hospitals. While conventional financial accounting would include consideration of taxes paid (Herzlinger and Krasker, 1987), critics argue that considering payment of taxes confuses community benefit with operating costs (Burda, 1995). Notwithstanding the relative merits of these arguments, a hospital that meets its community benefit obligations principally through tax payments probably substantially reallocates its community benefit, redefining both the community and the populations within the community to which it provides benefits. That is, the hospital’s “community” becomes all jurisdictions to which the hospital pays taxes (not just the local community with physical access to hospital services), and community benefits become distributed to populations in direct proportion to the amount of taxes that individuals and corporations otherwise would pay.

**Lower charges as a community benefit** received by **benefit.** The distribution of not-for-profit hospitals’ community benefits may also include the all patients that use the hospital in the form of lower charges relative to cost, compared to for-profit hospitals. This benefit accrues to most patients only indirectly (via lower health insurance prices and public program expenditures).

Some analysts have taken a more critical view of not-for-profit hospitals’ lower charge-to-cost ratio. Herzlinger and Krasker (1987) argue that not-for-profit hospitals’ low charge-to-cost ratios represent their propensity to spend “social equity” by failing to replace the assets that they consume. Examining pooled data on 563 of the 725 hospitals owned by the 14 major for-profit and not-for-profit chains in 1977 and 1981, they conclude that not-for-profit hospitals systematically performed worse than for-profit hospitals (when comparing charge-to-cost ratios). Moreover, adjusted for inflation and social subsidies, not-for-profit hospitals had virtually no internal capacity to finance future growth. In contrast, the for-profit hospitals generated funds from operations sufficient to replace capacity, pay taxes, and expand. Herzlinger and Krasker interpret this difference not as community benefit, but as a propensity by not-for-profit hospitals to transfer wealth from future patients to current patients. They warn that future generations of patients either will lack access to the same quality of plant and equipment or will have to pay to replace assets used by earlier generations.

**SECTION TWO: STUDY METHODS**

This section describes the process used to select case-study hospitals and to obtain both published and unpublished information about them.

---

11Evaluating California hospitals’ charges between 1981 and 1985, Rundall, Sofaer and Lambert (1988) concluded that investor-owned hospitals’ charge-to-cost ratios were substantially higher than those for other hospital types in every year analyzed.
Selection of hospitals

The case study hospitals were selected from all hospitals that filed annual hospital reports to the American Hospital Association (AHA) for at least five consecutive years between 1984 and 1994. These AHA reports were matched year-to-year to obtain a ten-year time series for each hospital that reported at any time during the period.

Hospitals were then grouped into seven strata. The first six strata included not-for-profit and public hospitals that, within five years after converting to for-profit status:

a) continued to be owned by the initial for-profit purchaser;
b) were resold individually to another for-profit owner; or
c) were resold as part of a larger portfolio transaction or corporate merger.

The seventh stratum included hospitals that, within five years of converting to for-profit status, reconverted to not-for-profit ownership. Within each of these strata, one hospital was chosen, based on two criteria: (1) maximizing geographic diversity and generally eliminating all hospitals in states from which a hospital in another stratum had already been chosen; and (2) including a mix of urban and rural hospitals.

Hospitals selected for study are identified in Table 1, organized by their original and subsequent ownership within five years of initial conversion. Hospitals’ conversion histories, provision of indigent care, market position, and other characteristics are described in detail within Appendix 1.

Corporate genealogies were constructed for the two major hospital systems, Columbia/HCA and Tenet Healthcare, to provide a factual basis for the interviews. These genealogies are portrayed in Appendix 2. The information we compiled also demonstrate the complexity of the hospital industry and the amount of change that it has experienced during a brief ten-year period of time. The amount and rate of change that these genealogies portray also helps to explain why many of the study’s hospital contacts could not accurately recount their own hospital’s ownership history.

Unpublished sources of information

Detailed information was obtained through a series of semi-structured telephone interviews; these interviews were conducted with hospital administrators and community representatives associated with the seven case-study hospitals during the spring of 1998. With one exception, at least one administrator and one community leader was interviewed about each
Table 1

<table>
<thead>
<tr>
<th>Original Ownership of Study Hospitals and Subsequent Merger or Acquisition Activity Within Five Years of Initial Conversion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Merger or acquisition activity within five years of initial conversion:</td>
</tr>
<tr>
<td>No change in hospital or parent company ownership</td>
</tr>
<tr>
<td>Hospital resold to another for-profit owner</td>
</tr>
<tr>
<td>Hospital resold to a not-for-profit owner</td>
</tr>
<tr>
<td>Hospital resold as part of the parent company’s merger or acquisition</td>
</tr>
</tbody>
</table>

sampled hospital. Those interviewed included an administrator of the hospital (such as the hospital’s CEO or CFO) and one community leader who had current or relevant past experience with the hospital. (The community leader selected for an interview was often a high-level official of the local health department or the director of a federally-qualified health center. In most cases, an administrator of another hospital in the hospitals’ service area also participated in the interviews.) Interviewees were questioned about the chronology of the hospital’s conversion, its market position, provision of indigent care and essential services, and impact of changing corporate control. To assure accuracy of reporting, a draft of this study was sent to respondents for their comments.

This case-study method provided a detailed historical context and a community

---

12 The intention of sampling some hospitals with five years of continuous ownership was to produce information about hospitals with relative stability following conversion. However, both hospitals selected in this stratum subsequently experienced corporate ownership changes after the five-year period: a private investment company bought Scott County Hospital’s corporate parent in 1996, and Tenet acquired Winona Memorial’s corporate parent (OrNda) in 1997.

13 Wheeler County Hospital’s ownership history is also complex. While AHA data first indicate for-profit ownership of Wheeler County Hospital in 1985, Health Care Management Corporation had purchased the hospital in 1983. In 1986, Basic American Medical purchased Health Care Management Corporation (acquiring Wheeler County Hospital as a “portfolio” purchase), but sold the hospital the next year (in 1987) to Comprehensive Health Care. In 1992, Basic American Medical (by then, itself owned by Columbia) repurchased Wheeler County Hospital, and then resold it in 1994 to its current CEO. On the basis of the AHA data, we classified Wheeler County Hospital as a hospital that had been individually resold to another for-profit owner, despite the brief period (during 1996) that Basic American Medical first owned the hospital as a portfolio purchase.

14 At only one hospital, Winona Memorial Hospital, did the hospital’s management decline to be interviewed. Consequently, information about this hospital relies entirely on interviews with community leaders, published press reports about the hospital, and audited financial reports (including bad debt and charity care costs for Winona and other Indianapolis hospitals) from the Indiana Department of Health.
perspective on several converting hospitals. The strength of the case-study as a research method — and the strength of this study — lies in its context and detail, which are lost in large, representative data bases. At the same time, it is important to recognize that the experiences of seven hospitals cannot necessarily be generalized to all hospitals throughout the United States.

Published sources of information

In addition to the information reported in the AHA data, several published sources were used for basic information about the sampled hospitals. These included the annual AHA guides and the 1997 edition of HCIA, Inc.’s Profiles of U.S. Hospitals. The Nexis-Lexis database also served as a valuable source for identifying and obtaining popular and trade press reports about the selected hospitals from the period immediately preceding conversion to the present.

SECTION THREE: OVERVIEW OF THE CASE-STUDY HOSPITALS

Characteristics of the case-study hospitals’ communities

The communities in which the study hospitals are located vary widely in their urban/rural nature, geographic location, population size and demographics, and per capita income (Table 2). Edgewater Medical Center is located in northwest Chicago, while Scott County Hospital is located in a rural mountaneous area of Tennessee. Edgewater’s service area (Cook County) has the highest per capita income of any of the case-study hospital communities, while Scott County has the lowest per capita income — averaging only half the per capita income of Cook County residents.

Wheeler County Hospital in Glenwood, GA has the smallest county population of the case-study hospitals, but it serves portions of several adjacent counties, and other acute care hospitals also operate in its service area. Scott County Hospital is a designated sole community provider and has the least populous service area – fewer than 20,000 people. Each of the urban hospitals is located in an area that is served by at least five other acute-care hospitals.

The hospitals’ service areas also differ in their demographic mix. Edgewater Hospital’s service area (Cook County, IL) has the highest birth rate, 18.4 births per thousand population, while Scott County Hospital’s service area (Scott County, TN) has the lowest (13.8 births/1,000). Wheeler County Hospital (Wheeler County, GA) has the lowest birth rate in its immediate service area (11.0 births/1,000), and the highest percentage of its population 65 years and over in both its immediate and larger service areas (16 percent and 12.8 percent, respectively). Lovelace Medical Center’s service area (Bernalillo County, NM) is the youngest of the case-study hospital communities: just 10.8 percent of Bernalillo County residents are age 65 or older.
### Table 2
Demographic and Economic Characteristics of the Case-Study Hospital Service Area

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Columbia Independence Regional Health Center (Independence, MO)</td>
<td>Jackson</td>
<td>635,637</td>
<td>15.8</td>
<td>12.9</td>
<td>$21,010</td>
</tr>
<tr>
<td></td>
<td>Cass</td>
<td>73,547</td>
<td>14.1</td>
<td>10.6</td>
<td>$17,486</td>
</tr>
<tr>
<td></td>
<td>Clay</td>
<td>165,981</td>
<td>14.2</td>
<td>10.2</td>
<td>$20,345</td>
</tr>
<tr>
<td></td>
<td>Ray</td>
<td>22,368</td>
<td>13.1</td>
<td>13.2</td>
<td>$14,582</td>
</tr>
<tr>
<td></td>
<td>TOTAL AREA</td>
<td>897,533</td>
<td>15.3</td>
<td>12.2</td>
<td>$20,438</td>
</tr>
<tr>
<td>Columbia Regional Medical Center (Montgomery, AL)</td>
<td>Montgomery</td>
<td>218,880</td>
<td>16.2</td>
<td>11.5</td>
<td>$20,014</td>
</tr>
<tr>
<td>Edgewater Medical Center (Chicago, IL)</td>
<td>Cook</td>
<td>5,136,877</td>
<td>18.4</td>
<td>12.4</td>
<td>$23,983</td>
</tr>
<tr>
<td>Lovelace Medical Center (Albuquerque, NM)</td>
<td>Bernalillo</td>
<td>522,328</td>
<td>16.2</td>
<td>10.8</td>
<td>$19,854</td>
</tr>
<tr>
<td>Scott County Hospital (Oneida, TN)</td>
<td>Scott</td>
<td>19,550</td>
<td>13.8</td>
<td>12.4</td>
<td>$12,200</td>
</tr>
<tr>
<td>Wheeler County Hospital (Glenwood, GA)</td>
<td>Wheeler</td>
<td>4,830</td>
<td>11.0</td>
<td>16.0</td>
<td>$13,673</td>
</tr>
<tr>
<td></td>
<td>Montgomery</td>
<td>7,635</td>
<td>13.8</td>
<td>12.1</td>
<td>$13,227</td>
</tr>
<tr>
<td></td>
<td>Toombs</td>
<td>25,276</td>
<td>17.8</td>
<td>12.4</td>
<td>$15,277</td>
</tr>
<tr>
<td></td>
<td>TOTAL AREA</td>
<td>37,741</td>
<td>16.1</td>
<td>12.8</td>
<td>$14,657</td>
</tr>
<tr>
<td>Winona Memorial Hospital (Indianapolis, IN)</td>
<td>Marion</td>
<td>817,604</td>
<td>17.7</td>
<td>11.9</td>
<td>$22,307</td>
</tr>
</tbody>
</table>


#### Characteristics of the case-study hospitals

The case-study hospitals vary considerably in their bed size, occupancy rate, and other operating characteristics (Table 3). Edgewater Medical Center has the most acute care beds: 212 beds in 1996. Edgewater’s and Wheeler’s beds are all designated for acute care. The other hospitals all also operate nursing care beds – in some cases as a substantial portion of their total beds (e.g., Winona Memorial Hospital and Columbia Independence Regional Health Center). The smallest study hospital, Wheeler County Hospital, also has one of the lowest average occupancy rate in 1996 – 35.4 percent. In contrast, Edgewater’s occupancy rate (a hospital known to offer limousine transportation service to Medicare and Medicaid patients in the Chicago area) has the highest occupancy rate – nearly 70 percent. Wheeler also has the least complex case mix, while Columbia Regional in Montgomery, AL has the most complex case mix.
### Table 3
Selected Operating Characteristics of Study Hospitals, 1996

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of acute beds</th>
<th>Acute beds as % of total beds</th>
<th>Acute bed occupancy (%)</th>
<th>Case mix index&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Columbia Independence Regional Health Center (Independence, MO)</td>
<td>165</td>
<td>52</td>
<td>61.5</td>
<td>1.44</td>
</tr>
<tr>
<td>Columbia Regional Medical Center (Montgomery, AL)</td>
<td>169</td>
<td>94</td>
<td>53.4</td>
<td>1.85</td>
</tr>
<tr>
<td>Edgewater Medical Center (Chicago, IL)</td>
<td>212</td>
<td>100</td>
<td>69.7</td>
<td>1.39</td>
</tr>
<tr>
<td>Lovelace Medical Center (Albuquerque, NM)</td>
<td>197</td>
<td>78</td>
<td>45.9</td>
<td>1.54</td>
</tr>
<tr>
<td>Scott County Hospital (Oneida, TN)</td>
<td>89</td>
<td>81</td>
<td>44.2</td>
<td>1.22</td>
</tr>
<tr>
<td>Wheeler County Hospital (Glenwood, GA)</td>
<td>40</td>
<td>100</td>
<td>35.4</td>
<td>1.09</td>
</tr>
<tr>
<td>Winona Memorial Hospital (Indianapolis, IN)</td>
<td>102</td>
<td>54</td>
<td>32.8</td>
<td>1.42</td>
</tr>
</tbody>
</table>

<sup>a</sup> The case-mix index is a measure of the complexity of the hospital’s Medicare cases relative to the national average. It is assumed to correlate with the complexity and cost of a hospital’s entire patient mix. A higher number indicates a greater case-mix complexity relative to the national average.

Five of the sampled hospitals serve as minor teaching hospitals, but none are members of the Council of Teaching Hospitals. Only the two rural hospitals, Wheeler County Hospital and Scott County Hospital, have no medical residency programs at all. All but Columbia Independence Regional are designated Medicare disproportionate share hospitals.

Two of the hospitals hold unusual positions in their communities.

- Scott County Hospital is a federally designated sole community provider; it is the only case study hospital that has no proximate competition. Although several hospitals operate on the edges of its service area, these hospitals serve small urban centers.

- Lovelace Medical Center in Albuquerque, NM is wholly owned by Cigna Corporation and operates exclusively within Cigna’s Lovelace Health Systems, Inc., a staff model HMO. With few exceptions, Lovelace draws its patients entirely from the Lovelace Health System.
SECTION FOUR:
DELIVERY OF CHARITY CARE

It was by coincidence that none of the hospitals selected are located in affluent regions or neighborhoods. Instead, they are located either in low- or middle-income areas, often described as “blue collar” areas, or in a business sector of the metropolitan area. Thus, for all but Independence Regional Health Center, we were able to locate a community health clinic that serves substantial numbers of indigent patients in the geographic area proximate to the study hospital.

Despite the proximity of low-income residents to most of the sampled hospitals, only one (Columbia Regional Medical Center in Montgomery, AL) is actively engaged in the delivery of care charity in its community (Table 4). Under an agreement struck by the hospital’s original ownership, the Daughters of Charity, Columbia Regional participates with two other in-town hospitals in a daily rotation of emergency room service in an effort to distribute the hospitals’ charity care load evenly. Although Columbia Regional continued to participate in this rotation arrangement, it is not known in its immediate community as a principal source of care for uninsured and low-income patients, in contrast to its not-for-profit history when indigent patients “automatically” went to Columbia Regional for care. Currently, Columbia Regional reports an uncompensated care burden (including both bad debt and charity care) of 10 to 15 percent of net revenue, but it is seen by other providers who serve indigent patients as having generally withdrawn from its commitment to charity care post-conversion. The relative uncompensated care burdens of other hospitals serving in the Montgomery, AL emergency room rotation were unavailable.

As a sole community provider, Scott County Hospital is also a potentially important source of care for the surrounding population. The hospital is located in a very low-income area of rural Tennessee, and TennCare patients represent 35 percent of the hospital’s annual inpatient days. Columbia Hospital Corporation acquired Scott County Hospital as a long-term lease arrangement with the county and, at that time, reportedly “bought out” the hospital’s remaining Hill-Burton indigent care obligation. A hospital representative reported that uncompensated care patients currently account for less than 10 percent of inpatient days; he seemed unfamiliar with unmet community needs regarding medically indigent patients. While Scott County does not have an unusually large proportion of older residents, Medicare patients account for about 60 percent of the hospital’s inpatient days. Its community outreach activities are focused on expanding the hospital’s Medicare and privately insured patient bases.

Consistent with Scott County Hospital’s low self-reported uncompensated care burden, one community contact reported that the hospital is now “very aggressive” in seeking payment for

\[15\] The only case-study hospital not designated as a disproportionate share hospital.
\[16\] For example, three other hospitals in the Montgomery area – including another Columbia hospital – have participated in a series of five meetings with Montgomery’s federally qualified health center to discuss services and to organize health screening fairs. Columbia Regional has not participated in these meetings.
covered services under Medicare and Medicaid. The hospital was reported to have hired a private company to collect patients’ payments for Medicare coinsurance and deductibles, sometimes from patients who were low-income. Both of the study’s community sources indicated their belief that new hospital management did not improve services for the poor. Yet, some capital improvements were made following for-profit conversion (largely in the form of aesthetic improvements to the reception area and repairs).

### Table 4

<table>
<thead>
<tr>
<th>Case-Study and Comparison Hospitals</th>
<th>Medicare discharges (%)</th>
<th>Medicaid Discharges (%)</th>
<th>Uncompensated care (est. % of revenues)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Columbia Independence Regional Health Center</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison hospitals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Center of Independence</td>
<td>46</td>
<td>3</td>
<td>8&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Truman Medical Center-East</td>
<td>30</td>
<td>13</td>
<td>na</td>
</tr>
<tr>
<td><strong>Columbia Regional Medical Center</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison hospitals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Columbia East Montgomery Medical Center</td>
<td>40</td>
<td>13</td>
<td>na</td>
</tr>
<tr>
<td>Baptist Medical Center</td>
<td>34</td>
<td>5</td>
<td>na</td>
</tr>
<tr>
<td><strong>Edgewater Medical Center</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison hospitals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Joseph Health Center &amp; Hospital</td>
<td>46</td>
<td>41</td>
<td>5</td>
</tr>
<tr>
<td>Norwegian-American Hospital</td>
<td>45</td>
<td>11</td>
<td>na</td>
</tr>
<tr>
<td>Methodist Hospital of Chicago</td>
<td>9</td>
<td>59</td>
<td>na</td>
</tr>
<tr>
<td><strong>Lovelace Medical Center</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison hospitals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaseman Presbyterian Hospital</td>
<td>12</td>
<td>17</td>
<td>0</td>
</tr>
<tr>
<td>University of New Mexico Hospital</td>
<td>47</td>
<td>4</td>
<td>na</td>
</tr>
<tr>
<td><strong>Scott County Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison hospitals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methodist Medical Center of Oak Ridge</td>
<td>51</td>
<td>35</td>
<td>&lt;10</td>
</tr>
<tr>
<td>The University of Tennessee Memorial Hospital</td>
<td>28</td>
<td>37</td>
<td>20</td>
</tr>
<tr>
<td><strong>Wheeler County Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison hospitals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jefferson Davis Hospital</td>
<td>54</td>
<td>24</td>
<td>na</td>
</tr>
<tr>
<td>Meadows Regional Medical Center</td>
<td>54</td>
<td>22</td>
<td>na</td>
</tr>
<tr>
<td><strong>Winona Memorial Hospital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparison hospitals:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methodist Hospital of Indiana</td>
<td>55</td>
<td>16</td>
<td>7&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Wishard Memorial Hospital</td>
<td>34</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td><strong>U.S. Hospital Average</strong></td>
<td>38&lt;sup&gt;b&lt;/sup&gt;</td>
<td>14&lt;sup&gt;b&lt;/sup&gt;</td>
<td>6&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Source: HCIA Inc., *Profiles of U.S. Hospitals*, 1998; Alpha Center communications with case study hospital representatives; Indiana State Department of Health (Acute Care), Medicare cost reports, Worksheets S-3, C-1, and G-2, fiscal year 1996.

(Note: “na” indicates that no estimate was available); U.S. Nat’l Center for Health Statistics, 1996.

<sup>a</sup>Reported as a percent of hospital costs.

<sup>b</sup>Percent discharges by expected payment.

Many of the county’s indigent patients, as well as TennCare and low-income Medicare
patients, now travel to Oak Ridge and the University of Tennessee Hospital in Knoxville (both some 60 miles distant from Scott County Hospital) for care. Scott County Hospital differs from these two hospitals in that its total public program discharge rate (combined Medicare and Medicaid) is much higher, the probable result of aggressive hospital management collection policies. Inferring from the combined Medicare and Medicaid discharge rate, Scott County Hospital’s privately insured patient base accounts for less than 10 percent of total discharges. As Scott County Hospital is a sole community provider, it is uncertain just where privately insured patients are treated.

Edgewater Medical Center in Chicago is notable both due to its low uncompensated care load and because it is a hospital that reconverted to not-for-profit status. The circumstances of Edgewater’s sale to for-profit ownership, resale to not-for-profit ownership (Denver-based Permian Health Care, Inc.), and current for-profit management may be of special interest in understanding some emerging aspects of not-for-profit hospitals. Within four years of its initial purchase and conversion to for-profit ownership, Edgewater’s owner and CEO (who remains as CEO) sold the hospital to a not-for-profit holding company. (Edgewater’s sale price was reported in the press to be 35 times the purchase price paid in 1989, $1 million). While one hospital administrator characterized this transaction as “returning the hospital to the community,” Edgewater’s not-for-profit corporate parent was incorporated in Denver, CO and owns primarily not-for-profit hospitals in California. Edgewater’s five-member board of trustees includes only one trustee who resides in Chicago, or even in Illinois, and Edgewater is managed by a for-profit company with no recognizable base in the community.17

Answering questions about delivery of charity care, all case-study hospitals located in metropolitan areas indicated that some community mechanism was available to provide uncompensated care; yet, only one hospital (Columbia Regional in Montgomery, AL) participates in such an arrangement. In Albuquerque, NM the community arrangement is explicit: indigent patients are expected to be seen by the University of New Mexico hospital, which is funded (from a dedicated county assessment on property) to serve medically indigent patients. Thus, Lovelace Medical Center, also in Albuquerque, is able to serve only Lovelace Health System enrollees; there is no sense in the community that the hospital has shirked an implicit obligation to provide charity care.18

In other metropolitan areas, the community arrangement to serve indigent patients is implicit. Indigent patients know to seek care from a particular public hospital, and other area hospitals feel no obligation to be significant providers of charity care. In Indianapolis, Wishard Hospital fills this role. Staffed by the University of Indiana Medical School, Wishard Hospital’s mission includes caring for the indigent; Wishard appears to be well-funded from local property...

---

17The for-profit company (Braddock Management) that has managed Edgewater maintains a close functional relationship with the not-for-profit parent corporation of the hospital. All of the parent corporation’s hospitals are managed by this for-profit company, and the company serves only that corporation’s hospitals. Since the case study was completed in 1998, Edgewater was “detached” from Permian and Braddock Management. It is now managed by a new for-profit Braddock spin-off company, based in Indiana.

18Lovelace bids on New Mexico’s Medicaid managed care business as companion business to its role as an insurer of state employees.
tax (although its tax support is not hospital-dedicated). Wishard’s high rate of Medicaid discharges (41 percent) suggests that it also has an unusually high uncompensated care rate, although no estimate of its uncompensated care rate was available. In contrast, Medicaid discharges comprise 16 percent of Winona Memorial Hospital’s total discharges; Winona Memorial also reported a small uncompensated care rate (7 percent).\(^{19}\) Winona Memorial is not now recognized as a major provider of indigent care in Indianapolis.

One of the initial objectives of this study was to obtain information about written contractual agreements made at the time of conversion concerning the provision of uncompensated care and continuation of essential services, and subsequent enforcement of those agreements. However, most of the study hospitals converted prior to the passage of state laws governing such transactions; only one hospital was able to provide a transaction contract (the long-term lease agreement for Scott County Hospital). When queried about contract language, the hospital contacts stated clearly that such language either did not exist or had become irrelevant. None of the study’s contacts could recall the existence of such agreements.\(^{20}\) These results – the nearly uniform lack of contractual agreements concerning provision of uncompensated care subsequent to conversion – forebode uneasiness among those who either advocate or legislate for the continued delivery of hospital charity care.

SECTION FIVE:
PROVISION OF ESSENTIAL SERVICES

All of the study hospitals maintained an emergency room prior to and following conversion to for-profit ownership through 1997, according to AHA data and the interviews with hospital officials. Study hospitals varied with respect to which additional services they provided following conversion. Each of the hospitals with trauma centers or obstetric services, often unprofitable, continued to provide those services after conversion. Only Edgewater Medical Center terminated any core service; Edgewater discontinued obstetric services a few years after conversion.

Changes in management associated with new hospital ownership often provide an opportunity for a fresh, critical review of the hospital’s services. Hospitals that change ownership may be more likely to alter service capacity than hospitals with stable ownership, according to those we interviewed. While other hospitals in surrounding geographic areas may have made service changes during the years considered, it became clear that many of the case-study hospitals

\(^{19}\)Similarly, Cook County Hospital in Chicago is known to be a source of care for the indigent. Gauging from the distribution of Medicaid discharges, the distribution of uncompensated care in Chicago may be less concentrated in a single, well-funded hospital than in Indianapolis. In Edgewater Medical Center’s proximate service area, Norwegian-American Hospital, a private not-for-profit facility, serves very high numbers of Medicaid patients; 59 percent of Norwegian-American’s discharges are billed to Medicaid. One community source noted Norwegian-American is relatively active also in serving low-income and uninsured area residents; data to confirm this perception were unavailable.

\(^{20}\) Scott County’s contract did contain written language covering these points, but the hospital contact for this study reported only “verbal agreements.”
discontinued a variety of important services in the years following conversion.

- Columbia Independence Regional discontinued its adult/adolescent psychiatric inpatient services. The study’s contact cited risk management concerns and the availability of another provider in the community as factors contributing to that decision. This contact reported also that the community had perceived Columbia Independence Regional to be an important resource for psychiatric services, although s/he was unable to point to an increased incidence of unmet need with the service’s discontinuation.

- Wheeler County Hospital discontinued its intensive care unit. One hospital administrator attributed the decision to quality-of-care concerns and low volume. He also said that the hospital would consider reopening the ICU if the hospital were able to appropriately staff it.

- Columbia Regional Medical Center in Montgomery suspended cardiac services for 12 months in early 1998 while retaining its certificate-of-need for those services. Columbia Regional had been the area’s only provider of cardiac services until 1997, when a rival hospital obtained a certificate-of-need to open another cardiac unit; this new unit quickly came to dominate the market, according to the study’s hospital contact. Columbia’s cardiac business had accounted for one-fourth of its revenues, but its cardiac volume dropped sharply and the hospital decided to suspend its program.

At the same time, several of the study hospitals have maintained, assumed, or expanded services important to their service communities since converting to for-profit ownership:

- Columbia Independence Regional Health Center in Missouri completed an extensive renovation of its emergency department that nearly doubled the department’s size.

- Edgewater Medical Center in Chicago is one of the few hospitals in its service area providing acute substance abuse detoxification care, according to the study’s community contact, and it is the only hospital in the area that will accept Medicaid patients for detoxification.

- Columbia Regional in Montgomery recently became the contractor for the state’s Gift of Life program, a Medicaid prenatal care and obstetrical services waiver program.

Obstetric services appear to be a service area targeted for scrutiny among several of the study hospitals. Decisions to provide or not to provide obstetric services appeared to involve a number of factors, including physician capacity, liability costs and concerns, the hospital’s willingness to accept Medicaid and uninsured patients (many of whom are also at high risk for medical complications, thus heightening hospital concerns about cost, quality, and liability), and the role that the hospital is trying to establish or maintain in the community.

- Scott County’s decision to lease the hospital to Community Health Systems was made in the midst of a dispute with the state health authority over the hospital’s de facto termination of obstetric services at the hospital, even though the state had denied the
hospital’s certificate-of-need application to discontinue these services. In the 1960s and 1970s, Scott County Hospital had performed 200 to 250 deliveries per year; by the mid-1980s, that number had dwindled to fewer than 15 annually. In 1990, there were no deliveries at the facility. In a compromise agreement with the state in 1989, the hospital agreed to a goal of delivering half of the county’s babies (that is, about 130 deliveries of the county’s 260 births per year, as of 1993). In fiscal year 1997, Scott County Hospital provided 76 deliveries. The community health center that provides prenatal care to approximately 80 women per year reported that only one or two clients each year deliver at Scott County Hospital. Both community contacts reported that county residents have become accustomed to traveling elsewhere for obstetric services, and that the hospital maintains that obstetric services are unprofitable, particularly since many pregnancies in the county are high-risk. One commented that the hospital would need to aggressively campaign for obstetric services patients to overcome its reputation for avoiding them. The issues surrounding obstetric services relate to physician staffing issues at the hospital – including physician retention, admitting privileges, and physician staff politics in a small community.

- Edgewater Medical Center in Chicago discontinued obstetric services in 1992, following conversion to for-profit ownership in 1989. Although one hospital administrator cited low volume as the principal reason for the decision, AHA data indicate that there were 783 deliveries at Edgewater in 1991.

- Prior to conversion, Wheeler County Hospital, also a rural hospital, discontinued obstetric services circa 1978. The community contact cited the lack of obstetricians in the area as the main reason the hospital no longer offered OB care. Patients in need of obstetric services now travel 20 to 30 miles to obtain them.

- Winona Memorial Hospital in Indianapolis has never offered obstetric services, but the local business press reported in mid-1997 that the hospital was planning to offer obstetric services in an effort to rebuild its image as a full-service community hospital. However, the community contact for this study expressed doubts that Winona, should it go through with its plans to offer obstetric services, could effectively compete with larger hospitals in the area for that business.

SECTION SIX:
IMPLICATIONS FOR STATE OVERSIGHT

Just how communities will fare in terms of access to care and who will assure continued services for the uninsured after conversion of local not-for-profit hospitals to for-profit ownership are essential questions that increasingly are being asked by consumers and public policy-makers.

[21] During the early 1990s, the hospital’s original for-profit owner had attempted to remake the hospital into a tertiary regional referral center and also had changed the hospital’s name. The current CEO has pursued a strategy of returning the hospital to its community roots and has returned the hospital to its original name.
alike. Almost all hospitals in this study were converted before state laws governing conversion transactions were passed. Therefore, it was difficult, if not impossible, for government officials to exert much influence over changes in health care delivery related to these hospital conversions in affected communities. More recently, however, a growing number of states have recognized the public interest at stake during and subsequent to a hospital’s change of ownership. The public’s interest includes: safeguarding the community from loss of essential health care services; safeguarding the value of charitable assets; and ensuring that the proceeds of the hospital sale are used for appropriate charitable purposes (Volunteer Trustees Foundation for Research and Education, 1998). It is only the first issue, safeguarding essential health care, that is the focus of this report.

Communities have sometimes questioned or opposed hospital conversions, “particularly when they fear the conversion might result in a hospital or some of its services being closed” (Bell, Snyder, and Tien, 1997). This fear is based on both research findings that compare and contrast behavior of not-for-profit and for-profit hospitals (described earlier), especially provision of uncompensated care and essential services, and historic experience. A conversion to for-profit ownership may change an institution’s basic mission, which may jeopardize access to care. At the same time, however, it is recognized that only a relatively small group of not-for-profit hospitals have provided the bulk of uncompensated care throughout the United States for many decades. Indeed, this study of not-for-profit hospital conversions indicated that only one of the seven hospitals was actively engaged in delivering charity care prior to conversion.

Debate engendered by hospital conversions over the value of hospitals to the communities they serve has compelled policy-makers and community activists to examine conversions more closely than in the past. In recent years, 14 states have passed legislation governing such aspects of conversion as continued provision of uncompensated care, maintenance of essential services, and the transfer of assets. This legislation has addressed both hospital sales and health plan conversion activities. Parameters of this legislation relating to hospital conversions are summarized in Table 5, state-by-state.

Hospital conversions, formerly considered simply private market transactions, offer the opportunity for active consumers to shape the policies and operations of the health care institutions that serve their communities. Requiring an open and public process and public disclosure about the proposed transaction terms help to encourage a community voice in the new institution’s strategic planning and to assure consideration of local health care delivery issues important to the public. Because of the consequences of loss of hospital services or change of mission, especially for those who are sick, frail, or poor, there is a growing recognition of both the right of the public to be involved in hospital conversions and the important role of the state in assuring an open process.

In nearly every state, the Attorney General is charged with protection of charitable assets. States could expand the Attorney General’s responsibilities in considering the community health impact of a hospital conversion. Options include:

---

22 The U.S. General Accounting Office found in 1998 that conversions were “not routinely subject to public disclosure.”
• Requiring public hearings to inform the public about the proposed conversion and broadening their scope to allow the opportunity for public participation or to receive public comment concerning the effect of the conversion on the community.

• Establishing an oversight process that includes the Attorney General’s or other state agency’s (1) determination of whether the proposed transaction would have a significant effect on the availability of health care services in the affected community; and (2) assessment of whether safeguards are in place to assure continued access to care for under- and uninsured patients, and availability of services traditionally provided by the hospital.

• Monitoring compliance with conditions of approval. States can establish a straightforward process for ongoing review of a converted entity and pledges made by the hospital buyer for maintaining health services. An enforcement mechanism is needed to assure compliance with conditions.

• Establishing reporting requirements for major health care service changes or termination, and annual reporting on provision of charity care.

After a hospital’s conversion, keeping a vital link between the local community and the parent hospital corporation is essential if the needs of the community are to be met. As health care is a local activity, some institutions have decided to include local representation on corporate hospital boards, to assure a community voice is maintained.

Since the passage of legislative initiatives governing conversions (and the unraveling of Columbia/HCA’s aggressive hospital purchasing strategy), the pace of hospital conversions has slowed throughout the United States. The public debate continues about the implications of not-for-profit conversions, sparking a broader discussion about what community benefits are provided by the not-for-profit hospital sector, in general. These public discussions are expected to facilitate more careful monitoring after conversions so that hospitals meet the terms of contractual and legal obligations to the community. They should also encourage health care institutions, communities, and state governments to critically examine the performance of not-for-profit hospitals in providing a health care safety net and access to care for all residents, including the uninsured.
### Table 5
**Hospital Sale and Conversion Requirements in Fourteen (14) States**

<table>
<thead>
<tr>
<th>State</th>
<th>AZ</th>
<th>CA</th>
<th>CT</th>
<th>DC</th>
<th>GA</th>
<th>LA</th>
<th>NE</th>
<th>NH</th>
<th>OH</th>
<th>OR</th>
<th>RI</th>
<th>SD</th>
<th>VA</th>
<th>WA</th>
</tr>
</thead>
<tbody>
<tr>
<td>State notification required</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>State/AG approval required</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Transaction documents on public record$^{23}$</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Public hearing required$^{24}$</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Referral to state health agency for review$^{25}$</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Evaluation by outside expert retained at expense of buyer and/or seller</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Compliance provisions</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Nonprofit to nonprofit transactions covered</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Community assessment/access to care provisions</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>Remedies and penalties</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>•</td>
</tr>
</tbody>
</table>


### SECTION SEVEN: CONCLUSIONS AND FUTURE DIRECTIONS

Overall, the conclusions that emerge from this study indicate that no contractual or mission-related commitments to meeting community needs directed the seven hospitals in their management of charity care and essential services after conversion. Rather, the needs and resources of each hospital and a competitive hospital environment have driven those decisions. For the most part, the hospitals in the study have not been considered primary community sources of charity care for the medically indigent, especially since conversion. This finding is consistent with emerging research that shows, on average, hospitals that convert to for-profit status provide less uncompensated care than other hospitals. With respect to essential services, the changes that

---

$^{23}$ Three more states require summaries only of transaction documents which are also on the public record.  
$^{24}$ Ohio and Rhode Island require a hearing specifically for use of the proceeds.  
$^{25}$ Some states authorize the Attorney General to retain other state agencies. These states are included.
did occur, both at the time of conversion and in the following years, did not necessarily represent a loss of services for the communities. While some services were reduced or eliminated, others were expanded. Hospital officials asserted that without the conversions and the resulting inflow of new capital, many of the hospitals might have been closed altogether. Thus, some argued that maintaining any services from certain hospitals was more than might have been available without conversion.

At the same time, hospital officials emphasized that converted hospitals enter a less stable management environment -- either due to new corporate culture or to successive re-sales of the hospitals -- and that each change of management generally occasions a fresh review of services offered. Apart from making it increasingly difficult for staff to keep track of their own hospitals' histories, the impact of this instability was not immediately obvious. It does, however, raise questions about the long-term availability of certain services. Management changes can occur frequently, either because of the new ownership’s corporate culture or because the hospital is re-sold to a succession of new owners. Frequent changes in management and ownership can affect whether the hospital follows any discernible new strategic directions, how the community perceives and therefore uses the hospital, and the extent to which the community is able to hold the hospital accountable for meeting the conditions of its initial conversion to for-profit status. (A change in the hospital name to one unfamiliar to the community also tends to accompany a change in ownership.) As almost all hospitals in this study were converted before state laws governing conversion transactions were passed, a comparable study of hospitals that converted after relevant laws passed could add further valuable insights into post-conversion relationships.

We learned also that change in a hospital’s delivery of charity care following conversion may relate both to the hospital’s behavior (during and after conversion) and to community perceptions about the new ownership. This is a new perspective, and one that has not been reported in emerging hospital conversion research. Press coverage about sale of the hospital commonly reinforces community expectations – accurately or otherwise – that charity care is less available. One community source noted that indigent patients are likely to be especially sensitive to a change in the hospital’s ownership. Another source indicated that a for-profit hospital corporation would need to actively seek indigent patients to overcome the community’s supposition that indigent patients were unwelcome there. At least one hospital directly signaled to the community that the new ownership would be unfriendly toward unpaid charges by posting prominent signs in the emergency room that full payment was due at the time of service. Nearly all the hospitals that we studied had become relatively invisible, or otherwise irrelevant, to the community providers who serve indigent patients after conversion. What was reported to us is consistent with much of the research literature; it suggests that for-profit ownership is likely to direct hospitals toward the market’s mean levels of uncompensated care, when before they may have operated above the market average.

Most hospitals that converted to for-profit ownership underwent a critical review of service capacity and profitability either before or after conversion. Reasons given for service changes included concerns related to low service volume or quality and availability of appropriate staff, as well as concerns about “breaking even” on a particular service. This sometimes produced a change in strategic direction that was most readily observable as decisions to terminate or to add some types of services. For example, Edgewater Medical Center terminated obstetric services
after having performed nearly 800 deliveries the prior year. At Wheeler County Hospital, the hospital administrator identified quality-of-care concerns as the basis for discontinuing ICU services after conversion. Independence Regional Health Center doubled the size of its emergency room but discontinued adult psychiatric services, citing risk management concerns as the reason. Because of the importance of in- and out-patient hospital services to communities, more oversight attention should be focused on hospital decision-making and consideration of alternatives related to termination of certain hospital services.

To the extent that a hospital undertakes a critical review and reorganization of services and management prior to conversion, it may be less likely to make strategic changes soon afterwards. The two rural not-for-profit hospitals that we observed had closed services prior to conversion, either in an attempt to improve their financial situation or potentially to make themselves attractive to a prospective buyer. Despite a state order to reinstate adequate staffing for obstetric services prior to conversion, for example, Scott County Hospital still does not staff obstetrics consistent with its agreement with the state, according to sources interviewed. In addition, many hospitals have a history of for-profit management prior to conversion (although none of the case-study hospitals was in this situation); for-profit ownership may have very little net impact on operations or decision-making in such a hospital.

The emergence of not-for-profit holding companies (sometimes with for-profit corporate parents) and for-profit management companies raises questions about whether for-profit and not-for-profit ownership status is any longer a meaningful distinction in predicting relative hospital behavior. One case-study hospital (chosen because it had reconverted to not-for-profit status) offers an excellent example of the complex ownership and management arrangements that may be increasingly common among not-for-profit hospitals. Edgewater Medical Center is a not-for-profit hospital, with a for-profit corporate parent, and operated through a not-for-profit intermediary; it is run by a for-profit management company with the same for-profit corporate parent. Edgewater also offers an example of a hospital that based decisions about for-profit and not-for-profit status principally (if not solely) on the relative cost of tax-exempt debt versus for-profit equity financing. Despite Edgewater’s current not-for-profit status and the low-income neighborhood in which it operates, it was reported that a survey of Illinois hospital charges by Meridian Resource Corporation rated Edgewater as the most expensive hospital in Chicago in 1994 and 1995 (Japsen, 1996).

This study is intended to offer insights to health policy-makers, advocates, researchers, and others. As with any research based on relatively few cases, these conclusions should not necessarily be generalized to all hospitals, either for-profit or not-for-profit. The strength of this study lies in its context and details, which elucidate complex relationships between hospitals and those they serve. The study suggests that the not-for-profit hospitals converting to for-profit status were not major providers of uncompensated care prior to conversion. It indicates how some hospitals reviewed and sometimes improved service capacity post-conversion. It highlights the effect of frequent changes in hospital management and ownership on surrounding communities, as well as consumers’ sensitivity to hospital changes after conversion. The study calls into question research findings based on simple models of hospital ownership or point-in-time estimates. Insights gained from this study may help explain why research results related to differences between for-profit versus not-for-profit hospitals, and what happens to hospital behavior post-conversion, may be insignificant in magnitude or actually conflict with each other.
References


Chollet, Deborah J., *Targeting Preventive Care in Fulton County: The Incidence of Hospital Uncompensated Care and Selected Responses*, The Urban Study Institute, Inc., 1993.


Gabay, Mary and Sidney M. Wolfe, *Who Controls the Local Hospital? : The Current Hospital Merger and Acquisition Craze and the Disturbing Trend of Not-for-Profit Hospital Conversions to For-Profit Status*, Public Citizen’s Health Research Group, June 1996.


APPENDIX 1: STATE HOSPITAL PROFILES

1. Columbia Independence Regional Health Center

Chronology

Columbia Independence was purchased in 1994 by Columbia/HCA from the Reorganized Church of the Latter Day Saints (RLDS). According to a hospital contact, the hospital was the only one owned by the church. It had become increasingly difficult to operate a stand-alone facility in a competitive environment; the hospital wasn’t losing money when it was sold, but it was facing an increasingly difficult environment.

Market Position

Columbia’s broad market area encompasses the metropolitan areas of Independence and Lee Summit, all counties in the east metro area of Kansas City, and counties east of Independence. It is located in an older part of Independence with an older, working- and middle-class population. An administrator at a competing hospital characterized Columbia as a quasi-tertiary facility that was clinically broad-based, and noted their trauma care as a distinguishing feature in the community. Both he and the study’s Columbia contacts characterized the market area as over-bedded. The administrator contact commented that, both prior to and following conversion, Columbia Independence has held fewer managed care contracts than competing hospitals, and is relatively more dependent on Medicare patients.

Provision of Indigent Care

According to the hospital’s figures, Columbia provides about twice the level of uncompensated care (charity care, partial debt forgiveness, and bad debt) as it had under RLDS ownership. In 1990-93, average net revenues were $67 million, and uncompensated care was $2.8 million. Since 1994, net revenues have averaged $84 million, and uncompensated care has averaged $5.5 million. In 1997, uncompensated care was $5.98 million, or 8 percent of net revenues. According to the study’s hospital contact, the increase has been the result of both a conscious decision on the part of the hospital and a change in the environment (i.e., an increase in the rate of uninsured). Since conversion, the hospital has renovated and nearly doubled the size of its emergency department, and a community contact noted that the hospital’s trauma services are an entrance point for uninsured patients, as well.

Community contacts noted that a public hospital serves as the main source of indigent care in the community, and that the outpatient clinics serving the indigent work with that hospital. They were surprised to hear that uncompensated care had doubled following conversion, but reported that one of them had recently used Columbia’s emergency department and had noted no explicit demands for payment or “wallet biopsies” prior to treatment. They speculated that Columbia is “striving for business” in a competitive environment, and is thus “getting people in” and then worrying about method of payment. They also commented that the hospital had recently become more amenable towards Medicaid patients as Medicaid payment rates have improved.
Essential Services

Columbia Independence has continued its emergency department, trauma unit, and obstetrics services. Since conversion, Columbia has made substantial capital investments that include renovations of the hospital’s emergency department that nearly doubled its size. In 1998, the hospital decided to terminate its adult and adolescent psychiatric services, citing risk-management reasons as the primary reason for the decision. The study’s hospital contact cited the availability of another community provider as one of the factors involved in the decision, but the study’s community contacts reported that some in the community were upset by the decision and felt that the closure left a service void.

Impact of Changing Corporate Control

A hospital contact reports that the major effect of conversion is that operational, personnel, and capital decisions are now ultimately made by the corporate office, not by a local board of directors. The function of the board has become consultative and was described as the hospital’s “link to the community,” providing input and feedback about community needs. Other changes include significant reductions in hospital administrative staff but a slight increase in bed staffing. Under Columbia ownership, the hospital made major capital expenditures in 1995 and 1996 ($5.6 and $5.2 million, respectively), although expenditures leveled off to approximately $3 million in 1997.

2. Columbia Regional Medical Center

Chronology

Prior to for-profit conversion in 1989, what is now known as Columbia Regional Medical Center was operated as St. Margaret’s Hospital by the Daughters of Charity. The Daughters had operated the hospital for approximately 80 years prior to conversion. The study’s hospital contact’s understanding of the circumstances leading to conversion was that the hospital was experiencing extreme financial difficulties. Humana purchased the hospital from the Daughters of Charity and renamed it Humana Hospital Montgomery. Humana spun off its entire hospital business in 1993 into a company called Galen, which was acquired that same year by Columbia Hospital Corporation.

Market Position

The Montgomery hospital market is marked by fierce competition among the local hospitals. Columbia Regional’s principal competitors are Baptist Hospital and Jackson Hospital, a physician-owned facility. According to a local hospital official who was in the area at the time of conversion, St. Margaret’s attributed its financial difficulties to its intense competition with Baptist. We were told that hospitals in the area use the state’s certificate-of-need process to impede efforts at expansion by competitors. Baptist recently won a six-year battle to obtain a
certificate-of-need to open a cardiac unit; Columbia Regional had been the only hospital in the area with a cardiac unit.

The hospital’s mix of business (as measured in patient days) is approximately ten percent discounted private pay (HMO and PPO), approximately 10-15 percent uncompensated care (charity care and bad debt), 55 percent Medicare, and 16 percent Medicaid (HCIA, Inc.’s Profiles of U.S. Hospitals).

**Provision of Indigent Care**

For approximately 20 years, three downtown hospitals (Montgomery/Columbia Regional, Jackson, and Baptist) have operated the “emergency room of the day” on a daily rotating basis. All three hospitals operate their emergency rooms continuously, but the designated ER system was designed to equitably distribute the burden of bad debt and charity care that an emergency room attracts. One hospital contact reported that there were concerns about whether Columbia would continue to participate in the emergency room rotation system after conversion, but the arrangement has continued through both Humana and Columbia ownership.

The study’s community contact described several shifts in the provision of uncompensated care in Montgomery during the past decade. He reported that during the 1980s, St. Margaret’s played a “key and pivotal role” in the community as one of two hospitals, along with Fairview Medical Center, that provided much of the uncompensated care; and that other hospitals in the area, including Baptist and Jackson, were “not doing their share.” He reported that at that time, indigent patients “automatically” went to St. Margaret’s or Fairview. Fairview closed in the late 1980s, a fact which may have contributed to St. Margaret’s financial difficulties.

Following St. Margaret’s conversion to Columbia Regional, the study’s community contact reported a shift in community perceptions about the hospital’s willingness to provide uncompensated care, apparently based on statements that Columbia made during the conversion. The community presumed that the for-profit hospital would behave differently than its not-for-profit predecessor, and Columbia Regional would have had to demonstrate aggressively that indigent patients were welcome in order to overcome the community’s presumption. Instead, the community contact reported the hospital withdrew from the community following its conversion and acquired a reputation among indigent patients for being less than welcoming. According to the community contact, “…they showed a different face after conversion.” In contrast, he reported that Baptist Hospital recently has refocused on greater provision of indigent care and greater involvement in the community, operating a free church-based clinic and conducting health fairs for the uninsured. He attributed Baptist’s shift in focus at least in part to the arrival of a new CEO.

**Essential Services**

Columbia Regional has maintained the hospital’s emergency room and trauma services and
has continued to participate in the emergency room rotation arrangement with two other hospitals. The hospital has also acquired a Medicaid maternity care waiver contract previously held by Baptist. The contract accounts for the vast majority of deliveries performed at the hospital.

Columbia Regional had been the only hospital performing open-heart surgeries in the immediate area until 1997, when Baptist obtained a long-sought certificate-of-need to open a cardiac unit. Baptist drew patients, some admitting physicians, and cardiac care staff away from Columbia’s cardiac program and, in early 1998, Columbia decided to suspend their cardiac program for 12 months while retaining the certificate-of-need. A Baptist official maintained that there was enough cardiac business for both hospitals (which was the basis for their certificate-of-need proposal) and that the sudden cessation of Columbia’s program caused a short-term problem for Baptist. Prior to Baptist’s establishment of cardiac services, Columbia’s cardiac program had accounted for 10-15 percent of patient days and one-forth of revenue.

Impact of Changing Corporate Control

While the study’s community contact asserted that the initial conversion to for-profit status had changed the community’s expectations for the hospital, he reported that the subsequent transfer of the hospital from Humana (Galen) to Columbia was transparent to the community. However, he also noted that management turnover has been significantly higher at Columbia than at either Baptist or Jackson. He recalled that Columbia has had four or five CEOs in the past eight or nine years, while Baptist and Jackson have had two and one, respectively, during the same time period. He also commented on the impact a CEO can have on a hospital’s community focus, and noted that the current CEOs at both Columbia and Baptist have heightened their hospitals’ efforts to reach out to the community. The hospital went through another change in 1998, when Baptist Hospital purchased a number of hospitals from Columbia, including Columbia Regional Medical Center.

3. Edgewater Medical Center

Chronology

Edgewater was founded around 1920 by Maurice Mazel, a physician. Mazel’s heirs struggled to run the hospital following his death in 1980, but the hospital began losing significant amounts of money by the late 1980s. Consultant Peter Rogan was brought in to run the hospital in 1988 and was the only bidder when the hospital was put up for sale in 1989, when he purchased it for $1 million and converted it into a privately held for-profit hospital. In 1994, Rogan sold the hospital to Permian, a not-for-profit holding company based in Denver, for $35 million. The hospital continued to be headed by Rogan, who received a salary from Permian, and was managed by a for-profit management subsidiary of Permian, Braddock Management. Edgewater signed a letter of intent in 1999 to purchase Grant Hospital (in Chicago) from an Arizona company that bought Grant Hospital (and Michael Reese Hospital) in late 1998 from Columbia/HCA.
Market Position

The Chicago hospital market was described by a number of contacts as crowded and considerably over-bedded. Edgewater is located in what was a “fairly affluent Jewish community” but which has experienced changes and is now a working-class neighborhood with many Russian and Hispanic immigrants. Although the study’s hospital contact characterized Edgewater as a “low-cost facility,” a survey of Illinois hospital charges by Meridian Resource Corporation rated Edgewater as the most expensive hospital in Chicago in 1994 and 1995 (Japsen, 1996). The study’s hospital contact reported that increasing Edgewater’s Medicare and Medicaid payer base was key to Rogan’s strategy of turning the hospital around.

Provision of Indigent Care

According to the study’s hospital contact, uncompensated care accounted for approximately five percent of the hospital’s revenues (on a charge basis), with less than half of that (two percent) provided as charity care. The hospital did accept Medicaid clients, and a community contact identified it as the only hospital in its service area providing substance abuse detoxification care for Medicaid patients. However, she also reported that Edgewater chose not to participate in two opportunities to interact with the community (in which other area hospitals participate): a district health council and a smaller, more local group of primary care providers that area hospitals also participate in. According to various news reports, Edgewater’s emergency room presents an unwelcoming front to potential indigent clients (including a sign demanding payment at the time of service rendered), while it has established clinics serving primarily Medicare clients in housing projects 10 miles away and provides transportation for such clients to the facility. According to another news report, Edgewater terminated an agreement with a community health center to accept their patients shortly after Rogan assumed management of the hospital. According to the clinic’s director, Edgewater had expected at least half of the referred patients to be covered by Medicaid or Medicare, but nearly all of them were uninsured.

Impact of Changing Corporate Control

Edgewater has had the same CEO from its initial conversion through its reconversion, to the present time. The hospital has paid a for-profit management for management services; one news report asserted that the management fees paid far exceed the industry norm.

4. Scott County Hospital

Chronology

Scott County Hospital opened as a county-owned public hospital in 1956. In November 1989, it was leased by the county to East Tennessee Health Systems, a subsidiary of Community Health Systems. The 20-year lease is reviewed and renewed in five-year increments; renewal is at CHS’s discretion. The county continues to own the building and land; all hospital staff are employees of Community Health Systems and the county retains no operating control.
The hospital was stressed financially and on the verge of closure prior to conversion, according to both a hospital contact and a community contact. The hospital received little money from the county and was expected to be self-supporting, although the county would “bail them out from time to time.” The hospital received no reimbursement from the county for uncompensated care. In the period preceding the lease agreement, vendors were insisting on cash-on-delivery sales terms, and the hospital was having difficulties meeting payroll. According to an administrator, the county had never invested in capital improvements to the facility.

At the time of conversion, the county examined proposals from several management companies before choosing Community Health Systems. Under the lease agreement, CHS is entitled to keep all profits from operation of the hospital for the first five years; in subsequent years, CHS is to pay the county five percent of profits exceeding $700,000 annually.

**Market Position**

Scott County is located in a rural, mountainous area of Tennessee. Scott County Hospital is the only hospital within a 50-60 mile radius. (According to one news report, Community Health Systems specializes in purchasing hospitals that are sole community providers.) Hospitals in surrounding counties include the University of Tennessee Hospital in Knoxville, Somerset, St. Mary’s, Park West, Baptist Medical Center, and Oak Ridge. Major community employers include two industrial employers (with 750-1000 employees) and, according to one community contact, the hospital itself.

The hospital’s mix of business (as measured in patient days) is 60 percent Medicare, 20 percent TennCare, less than 10 percent uncompensated care, and the remainder is private pay. According to one community contact, private pay patients in particular are welcome at and use the various hospitals in surrounding counties, rather than using Scott County Hospital.

5. Wheeler County Hospital

**Chronology**

While the AHA data first indicated for-profit ownership of Wheeler County Hospital in 1985, Health Care Management Corporation purchased the hospital in 1983. In 1986, Basic American Medical Purchased Health Care Management Corporation (acquiring Wheeler County Hospital as a “portfolio” purchase) but sold the hospital the next year (in 1987) to Comprehensive Health Care. In 1992, Basic American Medical (by then, itself owned by Columbia) repurchased Wheeler County Hospital and then resold it in 1994 to its current CEO.

**Market Position**

Wheeler County Hospital is the only hospital in Wheeler County; its market area also encompasses parts of Montgomery and Toombs counties. The nearest competing hospital is in Tombs, approximately 20 miles away. In 1997, approximately 60 percent of bed days were
Medicare and 15 percent were Medicaid. On the day of the interview, the study’s contact reported that 90 percent of the beds were occupied by persons dually eligible for Medicare and Medicaid. The hospital’s strategic direction since 1993 has been to emphasize outpatient and diagnostic services; outpatient services currently comprise approximately one-quarter of revenues.

Provision of Indigent Care

The study’s hospital contact maintained that indigent care was “not an issue” because the hospital accepted whomever the physicians admitted, and that the hospital ran the risk of alienating physicians if they refused admittance to indigent patients. He reported that the hospital attempts to gain Medicaid certification whenever possible, and that the state will grant (presumptive) Medicaid eligibility in some situations.

Provision of Essential Services

Prior to conversion, the hospital discontinued obstetric services in 1978. The community was unhappy with this decision, according to a community contact. In 1993, the hospital decided to discontinue intensive care unit services; the study’s contact cited quality of care and low volume as concerns driving that decision. He reported the hospital had been able to retain three board-certified foreign medical graduates under the J-1 visa program (which permits foreign medical graduates to practice in the U.S. if they agree to practice in under-served areas) and are considering reopening the ICU.

Impact of Changing Corporate Control

The study’s hospital contact reported that following conversion, most hospital personnel remained, and that changes have occurred principally at the top. He commented that public hospitals are prone to over-staffing and that proprietary hospitals are “leaner,” although he reported that staffing changes at Wheeler were made primarily through reassignment. He also commented that new ownership forces a review of services and relationships with the staff and community physicians, and that the new owners may “value” services differently than previous ones.

6. Winona Memorial Hospital

Chronology

Winona Memorial Hospital was founded by an Indianapolis physician in 1947 and named after his mother. In 1984, the founder became concerned about Winona’s ability to compete in a changed environment and decided to sell the hospital and use the proceeds to endow a cancer research foundation. He sold the hospital to Republic Health Corporation in 1984. Republic went through Chapter 11 bankruptcy and reorganization proceedings around 1990, and changed its name to OrNda in 1992. OrNda was acquired by Tenet in early 1997.
Winona changed its name to Midwest Medical Center in 1991 as part of an effort to reposition itself (see discussion below), but then changed its name back to Winona in 1994.

Market Position

Winona is located in the near north-side area of Indianapolis, in an area of low- to middle-income neighborhoods. It was characterized in news reports and by the study’s community contacts as a niche hospital operating in the shadow of much larger hospitals, including Methodist, the state’s largest hospital. Other area hospitals include St. Vincent’s, St. Francis, the Clarian Health Partners system (which includes the Indiana University Hospital, Methodist Hospital, and Riley Children’s Hospital), and Wishard (a public facility). The study’s contacts described it as a niche hospital doing many surgical procedures but offering little in the way of emergency services or services for women and children. However, one contact added that Winona “serves what it serves well” and that patients and physicians are comfortable with the facility and the services it provides. He also characterized Winona as the hospital most hospitable to minority physicians and reported that many of the city’s minority physicians are on staff there.

Under Republic ownership, Winona attempted to reposition itself in the community from a niche community hospital to a regional referral center. As part of those efforts, it changed its name to Midwest Medical Center in 1991 and reconfigured its medical staffing. Those efforts were unsuccessful: the hospital lost money (between $700 thousand and $3 million each year between 1991 and 1995), and name recognition dropped for several years after the change. The current CEO changed the name back to Winona and began steering the hospital back to its “bread and butter” community hospital roots in 1994. Although the hospital has resumed making money, it is still perceived as a relatively marginal niche player in the market; its plans to begin offering obstetric services were met with skepticism by both of the study’s community contacts. One rationale for offering obstetrics is to attract more managed care patients; one article reported that while Winona had 27 contracts with managed care providers in 1997, Methodist had 68.

Provision of Indigent Care

According to the study’s community contacts, indigent care in Indianapolis is provided primarily by Wishard County Hospital, a public hospital funded partly by a property tax. The study’s contacts characterized it as a well-funded, high-quality institution staffed by Indiana University Medical Center physicians. According to the study’s contacts, indigent clients “mostly go to Wishard”; Winona has never served a lot of low-income people, and doctors “know where to send their patients.”

Provision of Essential Services

Because of Winona’s niche position in the market, it offers no unique essential services. Although it operates an emergency department, one community contact characterized it as a small-scale operation, and the hospital has only recently begun to consider offering obstetrical services.
Impact of Changing Corporate Control

Winona experienced two radical shifts in strategic direction in the early to mid-1990s, first towards remaking itself into a specialty referral center, and then back again towards its community hospital roots. It is difficult to disentangle the relative influence of the hospital’s corporate owners from that of its CEO during that period; during the early 1990s the hospital had three CEOs in three years, but the current CEO (who was responsible for turning Winona back towards a community-hospital niche) has been there since 1994. Its corporate parent, OrNda, was experiencing difficult times of its own during that period as it struggled to emerge from reorganization. We were unable to discern any changes resulting from the acquisition of OrNda by Tenet in early 1997, although the hospital’s public affairs officer cited the purchase (and impending changes) as the reason for declining to be interviewed.
APPENDIX 2: CORPORATE HISTORIES

Columbia/HCA Corporate

1988
Group
American
Medical International)

1989

1990
HEI Corporation

1991

1992
Basic American
Medical

Humana, Inc.

1993
Medical Care
America, Inc.

Galen
Health Care, Inc.
(spin-off of all
hospital business)

1994

1995

Columbia/HCA
Healthcare Corporation

Epic Healthcare
(spin-off of
HCA in 1987)

Columbia Hospital
Corporation

Quorum Health Group
(spin-off of HCA, was
formerly called HCA
Management Co.)

Columbia Hospital
Corporation

Healthtrust Inc. – The
Hospital Company
(Spin-off of HCA in 1987)

Columbia Healthcare
Corporation

Columbia/HCA
Healthcare Corporation

Columbia Hospital
Corporation

Columbia Hospital
 Corporation

HCA – Hospital
Corporation of America

Healthtrust Inc. – The
Hospital Company
(Spin-off of HCA in 1987)

Columbia Hospital
Corporation

HCA – Hospital
Corporation of America
APPENDIX 2, CONTINUED

Tenet Genealogy

1989
National Medical Enterprises, Inc.

1990
The Hillhaven Corporation (spin-off of NME)

1991

1992

1993
American Healthcare Management, Inc.

1994
OrNda HealthCorp

1995
Tenet Healthcare Corporation

1996

1997
Tenet Healthcare Corporation