

NICHOLAS C. PETRIS CENTER
ON HEALTH CARE MARKETS AND CONSUMER WELFARE
UNIVERSITY OF CALIFORNIA, BERKELEY
SCHOOL OF PUBLIC HEALTH

CALIFORNIA'S CLOSED HOSPITALS, 1995-2000

JANUARY 2001, REVISED APRIL 2001

Nicholas C. Petris Center
on Health Care Markets and Consumer Welfare
University of California, Berkeley
School of Public Health
2150 Shattuck, Suite 525
Berkeley, CA 94720
(510) 643-4100 phone/ 643-4281 fax

Director, Richard Scheffler, PhD

Mission Statement

The Center will help to guide public policy by creating the data and conducting the research needed to understand today's complex health care market. It will provide up to date information on changes in the health care system that may impact the health care marketplace and alter its capacity to provide high-quality care at competitive prices. It will assess issues related to the welfare of California consumers, especially affordability, availability and access to health care with a particular focus on low and moderate-income consumers. It will concern itself with the role of consumer choice and the participation of front-line workers in the health care delivery system. The Center will conduct studies and provide objective information to lawmakers, regulators, consumer-advocates, health care providers and the public at large.

Petris Center Advisory Committee

Tangerine Brigham, MPP Director of Policy and Planning San Francisco Department of Public Health	Paul Feldstein, PhD Professor, School of Business University of California, Irvine
Kathleen Foote Supervising Deputy Attorney General Antitrust Section California Department of Justice	H.E. Frech III, PhD Professor of Economics University of California, Santa Barbara
Deborah Haas-Wilson, PhD Professor of Economics Smith College	Sherry Hirota Executive Director Asian Health Services
Patrick Johnston Former California State Senator Stockton	Ted Keeler, PhD Professor of Economics University of California, Berkeley
Eliseo Medina Executive Vice President, Western Region Service Employees International Union	William Powers Legislative Director Congress of California Seniors
Lourdes Rivera, PhD, JD Staff Attorney National Health Law Program	Harry Snyder, JD Senior Advocate Consumers Union
David Werdegar, MD, MPH Former Director Office of Statewide Health Planning and Development	Valerie Wilk Public Policy Analyst American Federation of State, County and Municipal Employees
Bill Lockyer (ex-officio member) Attorney General State of California	Edward Penhoet, PhD (ex-officio member) Dean, School of Public Health University of California, Berkeley

CALIFORNIA'S CLOSED HOSPITALS, 1995-2000
A Project of the Nicholas C. Petris Center
on Health Care Markets and Consumer Welfare
University of California, Berkeley, School of Public Health

Hospital Closure Project Staff:

Rachael Kagan, MA; Lisa Simonson Maiuro, PhD; Julie Schmittdiel, MA; Wil Yu¹

BIOGRAPHIES

Richard Scheffler, PhD is the Distinguished Professor of Health Economics and Public Policy at the University of California, Berkeley, School of Public Health and Goldman School of Public Policy. He teaches health economics, international health economics and the economics of medicine and managed care. His research areas include healthcare markets and workforce, health insurance, mental health economics and health system reforms in Western and Eastern Europe. Scheffler serves as Director of the Petris Center.

Rachael Kagan, MA is a healthcare policy and business writer who previously covered regional healthcare for the Oakland Tribune and the ANG Newspaper Group. She has written about healthcare antitrust, managed care, the uninsured, medical education and medical ethics. Her work has appeared in *Ms. Magazine*, *The Nation*, *NurseWeek* and *Modern Physician* magazines. Kagan earned a master's degree in journalism from Syracuse University and a bachelor's in history from Macalester College. She is the Petris Center's Publications Director.

Lisa Simonson Maiuro, PhD is a former Deputy Director of the Office of Statewide Health Planning and Development, Health Planning and Policy Division. Her work has focused on directing applied health policy research in a managed care environment, healthcare antitrust and statistical analysis. She has served as a consultant in antitrust matters for the Federal Trade Commission and the California Attorney General and acted as an expert witness for the Department of Justice. Maiuro earned her PhD from UCLA/RAND Center for Health Policy Studies. She now works as an independent consultant, providing healthcare financial and market analysis.

Julie Schmittdiel, MA received her bachelor's degree in Mathematics from the Massachusetts Institute of Technology, and her master's degree in Biostatistics from University of California, Berkeley. She has previously worked as a consultant at Kaiser Permanente Northern California's Division of Research, where her research interests included differences in primary care delivery by physician specialty and gender, and the impact of patient choice on satisfaction. She is a pre-doctoral trainee with the Agency for Healthcare Research and Quality, currently pursuing her PhD in Health Services and Policy Analysis from the University of California, Berkeley.

Wil Yu received his bachelor's degree in Cognitive Science from the University of California, Berkeley. He served as Research Associate at the Petris Center until January 2001. Currently, he is a Project Manager for the Health Technology Center in San Francisco, where he directs research on current and future health technologies. He will receive a master's in public health from the University of California, Berkeley, in May 2001.

¹ **Wendy Dyer, MS**, joined the Petris Center as Staff Research Associate in March 2001. She assisted in creating the revisions to the final version of this report.

FINAL REPORT

CONTENTS

Executive Summary.....	1
Map: Closed Hospitals in the State of California	
Introduction and Methodology.....	3
Findings.....	6
Distribution and Characteristics of Closed Hospitals.....	6
Table 1: Year of Closure for Closed General Acute Care Hospitals, 1995-2000	
Figure 2: Licensed Beds of Closed Hospitals Compared to Licensed Beds of General Acute Care Hospitals in 1999	
Figure 3: Distribution of Closed Hospitals by Licensed Beds	
Figure 4: Closed General Acute Care Hospitals, 1995-2000, by Ownership	
Figure 5: Closed Hospitals by Ownership Compared to All General Acute Care Hospitals in 1996 and 1999	
Figure 6: Proportion of Revenues and Discharges from Medicare and MediCal for Closed Hospitals	
Figure 7: Average Proportion of Revenue and Discharges from MediCal – Comparison of Closed Hospitals	
Figure 8: Average Proportion of Revenue and Discharges from Medicare – Comparison of Closed Hospitals	
Reasons for Closure.....	11
Figure 9: Net Patient Revenue per Bed for Closed Hospitals	
Figure 10: Net Income per Bed for Closed Hospitals	
Figure 11: Patient Days for Closed Hospitals: 1, 2 & 3 Years Prior to Closure	
Public Reaction.....	15
Current Use of Hospital Buildings and Land.....	16
Impact and Location of Other Nearby Hospitals.....	17
Maps: Closed Hospitals in Los Angeles, San Diego, Central California, Northern California, Tulare and Santa Maria	
Conclusion and Areas for Further Study.....	18

Appendices.....	21
Appendix A: Closed Hospitals and Financial Performance	
Appendix B: Chart of Hospitals Excluded from Study	
Appendix C: Chart of California's Closed Hospitals, 1995-2000	

FINAL REPORT

EXECUTIVE SUMMARY

The Petris Center on Health Care Markets and Consumer Welfare studied short-term general acute care hospitals that closed in California during the years 1995 to 2000. We identified 23 closures, 11 of which took place at for-profit facilities. The vast majority took place in urban areas, and they were most often in southern California. More than half of the closed hospitals had fewer than 100 licensed beds. Ten of the closed hospitals had changed ownership within three years prior to their closure. All the closed hospitals claimed, and demonstrated, financial distress prior to closing.

To create this report, we first set out to document and verify the closures. We then described the closed hospitals, in terms of tax status, location, bed size and other factors. We analyzed the financial status of the group of closed hospitals in the three years prior to closing. We looked for public reactions or objections to the closure, as best we could find them from press reports and other public information. We further assessed what happened to the vacant facilities, and the location of other nearby hospitals. Using this information, we then were able to draw some overall conclusions about California's closed hospitals. Highlights of our findings are presented in the bullet points below. A complete report of the project follows.

*23 California general acute care (GAC) hospitals closed between 1995 and 2000.

*The largest proportion of those that closed, 11 hospitals or 48 percent, were for-profit enterprises. Statewide, however, for-profits made up less than a third of hospitals in both 1996 and 1999.

*Only four of the hospitals closed were in rural areas.

*The Los Angeles area experienced the greatest number of closures: 11 hospitals. Four hospitals also closed in the San Diego area, making southern California the region with the greatest number of closures, at 15 hospitals or 65 percent of closures. This clustering is illustrated in the state of California map that follows the executive summary.

*Nearly half of the closed hospitals, 11, had 1-99 licensed beds. These are small hospitals. Statewide, the largest proportion of hospitals in 1999, 33 percent, fell into the 100-199 bed category.

*Ten of the closed hospitals had changed ownership at least once within the three years prior to closure.

*Each of the closed hospitals experienced declining reimbursements, income per bed and utilization in the year prior to closure. As a group, they performed worse financially than the state's operating general acute care hospitals did in 1999.

*More than twice as many closures took place in the second half of the period studied, when 16 hospitals closed, as in the first, when seven closed.

*The total number of hospital beds eliminated in the 23 closures represents 3.3 percent of licensed hospital beds and 3.6 percent of available hospital beds statewide in 1999.

*In two cases, the hospital closure removed all hospital care within a 15-mile radius. In another two cases, the remaining open hospital facilities grazed the edge of that circle.

*Though there were many actors closing California hospitals during the mid to late 1990s, two hospital systems were the major players. Tenet Healthcare Corp. was the most active, participating in at least five closures during the period studied. Catholic Healthcare West was the second most active, closing three hospitals.

*A public reaction or objection to the hospital closure was recorded in seven of the 23 cases. These included concerns about the reduction or elimination of reproductive health services, complaints about the short-notice of closure, questions about whether the remaining facilities would adequately be able to handle a higher patient load, anticipated problems connected to longer travel time to an existing hospital, and fundamental criticisms of the hospital owner's commitment to the community.

INTRODUCTION and METHODOLOGY

INTRODUCTION

In October 2000, The Petris Center on Health Care Markets and Consumer Welfare, a research organization at the University of California, Berkeley, School of Public Health, took on the job of creating a taxonomical list of all general acute care hospitals in California that closed between 1995 and 2000.

The assignment came to us because of our membership on the California Attorney General's Charity Health Care Task Force,¹ a body that found itself increasingly preoccupied with hospital closures over its several meetings during 2000. However, the paucity of overall and comparative information about our state's recent hospital closures made the task force's job of discussing, reacting to and evaluating them piece meal at best, and at worst, frankly out of reach.

Thus, we have put together the only effort that we know of to collect and synthesize standardized information about the California hospitals that closed in the second half of the 1990s. For the first time, we can now document and describe the 23 general acute care (GAC) hospitals that closed. We know now that most of the closures took place at for-profit facilities, in urban areas, in southern California. The vast majority of those closures occurred in places where there were other hospitals within 15 miles. Small facilities, of less than 100 licensed beds, composed the largest proportion of closed hospitals. In fact, we found that the total number of hospital beds eliminated by the 23 closures represents just 3.3 percent of the licensed hospital beds statewide in 1999, and 3.6 percent of the available beds for that same year.²

We also saw an acceleration in closures, with more than twice as many taking place in the second half of the 1995 to 2000 period, when 16 hospitals closed, as in the first, when seven closed. We have established that two hospital systems were the most active in closing facilities, and that many closed hospitals had changed hands shortly before closing.

We discovered that the public objected to fewer than half of the closures. But when communities did voice concerns, they raised substantial questions about reduction or elimination of services, capacity of the remaining hospitals, longer travel time to the next-closest hospital and the hospital owners' focus on the bottom line over their commitment to the community. Indeed, money played a part in these decisions, and we found that most of the closed hospitals claimed, and demonstrated, financial hardship before closing. That aspect of closure is discussed both in the body of this report, and in Appendix A, for readers seeking a more technical, detailed examination of finances.

Conducted on a short, three-month time table, the report surely has shortcomings. It does not, for instance, offer an in-depth analysis of the impact – on the community,

¹ Richard Scheffler, the Petris Center's Director, serves on this Task Force.

² There are three different types of hospital beds defined by the Office of Statewide Health Planning and Development. The largest group is licensed beds and represents the total number of beds for which a hospital is licensed, though the beds may not currently be in use, or even ready for use. The next-largest group is available beds, which are the average daily number of beds physically existing and actually available for overnight use, regardless of staffing levels. The smallest group is staffed beds, which are the beds for which there are sufficient staff and equipment already assigned to care for current and incoming patients.

consumers, providers or the market – of the individual closures. It does not examine closely what special services may have been eliminated by a particular hospital closure. Nor does it analyze individual hospitals in the context of system membership, in the cases where closed hospitals belonged to larger chains.

The report does not seek to evaluate whether these particular hospital closures, or the phenomenon of hospital closures in general presents a positive or negative event. It could be that closing a poorly performing or under utilized hospital strengthens the local delivery system by eliminating dead weight. However, a hospital closure also could deprive a community of access to care, be it primary, emergency or specialty services. These are important issues, but they exceed the parameters of this study.

To accomplish our task we put together a research team. Richard Scheffler provided overall direction and guidance. Lisa Simonson Maiuro conducted the financial analyses, deciphered the OSHPD data, created the maps and most of the graphs seen throughout the report and wrote Appendix A, providing further financial information. Julie Schmitt diel delved into the American Hospital Association database, placed calls to hospital systems and quantified the information gathered in the charts found in Appendix B and C. Wil Yu searched the Internet and libraries for press accounts and other forms of public information about the closures. Wendy Dyer conducted additional research during the revision process and created the graphs depicting the payer mix of the closed hospitals. Rachael Kagan coordinated the project and wrote the final report.

METHODOLOGY

An overview of the study methodology follows.

To start, the Attorney General’s office provided us with a list drawn up by the California Healthcare Association of 29 hospitals to study. We set about to verify that each of those hospitals fit the criteria for the report. That is, they must be short-term general acute care (GAC) hospitals in California that closed between 1995 and 2000. In our search, we found seven other hospitals to consider, bringing the total up to 36. Of that group, 13 were subsequently disqualified. Three turned out to be psychiatric facilities, one was a nursing home, four closed before 1995, two were still open, though under another name, and for three there were no data available after 1994.³ The 13 excluded hospitals appear in Appendix B.

With our report winnowed down to 23 hospitals, we then sought to obtain the following information about each one:

- 1) Name of hospital
- 2) City in which it was located

³ The three hospitals – Mono General Hospital in Bridgeport, Rio Hondo Hospital in Downey and Avenal District Hospital in Avenal – do not appear in OSHPD financial records after 1994, nor in any press accounts over the period studied. OSHPD reports do show that the Avenal hospital had its licenses suspended in 1992, but it does not appear in the agency’s financial records in 1995 or thereafter. Therefore, all three were excluded from the report because we could not verify that they had closed between 1995 and 2000.

- 3) Date of closure, by year
- 4) Size of hospital, measured in licensed beds⁴
- 5) Owner at time of closure, and three years prior
- 6) Nature of owner (for-profit, non-profit, government/district)
- 7) Official reasons given for the hospital closure
- 8) Financial condition of hospital at time of closure, and in the three years prior
- 9) Public reaction to the hospital closure
- 10) Brief history of the hospital
- 11) Current use of the hospital land and buildings
- 12) Local impact of closure, as reported
- 13) Location of surrounding still-open hospitals, within 15 miles
- 14) Payer mix of the closed hospitals
- 15) Whether there were any attempts to sell the closed hospitals prior to closure

To examine the above characteristics of the 23 hospitals, we relied on the following sources:

1. Office of Statewide Health Planning and Development (financial data⁵, hospital type, licensed bed count, utilization, ownership, location, date of closure, location of surrounding hospitals, payer mix)
2. American Hospital Association (ownership information, hospital type)
3. Newspaper accounts, press releases, published reports, Internet search sites (date of closure, reasons for closure, public reaction, ownership information, impact of closure, history of hospital, current use of site)
4. Phone calls to hospital owners, where necessary and possible (confirm ownership status, date of closure, learn official reasons for closure, plans, if any, made for transferred patient base, inquire about attempts to sell facility)
5. Corporate 10K Reports (ownership information)
6. DataQuick, San Diego-based property tax database (current use of former hospital site)

We consulted each of the above sources in search of all 15 points of information about each hospital. However, in some cases, no information was available. For instance, in only 15 cases were the official reasons for closure discovered. Also, we found information on the current use of the land and buildings only for 11 of the 23 hospitals. Likewise, the more in-depth, or qualitative elements such as public reaction, impact and history were often hard to track down. For the more empirical characteristics – name, city, number of beds, owner, tax status, year of closure, financial condition, location of nearby hospitals – we found information for each of the 23 hospitals studied. For readers

⁴ We chose this measure as it was the steadiest number among the three types of beds: licensed, available and staffed. Among beds, licensed ones are the least likely to change often, so they provided the most constant point of comparison between closed hospitals over a period of years and open general acute care hospitals in 1999. The financial analysis also relies on licensed beds, as seen in figures 9 and 10.

⁵ Three years of the most currently reported financial data were drawn from the OSHPD Annual Disclosure Reports for each of the closed hospitals.

seeking a more detailed, technical explanation of the financial analysis, see Appendix A of this report.⁶

Sometimes sources conflicted. When that happened, we defaulted to OSHPD, which we considered the most reliable source, since California hospitals are required by law to report financial and utilization data to that agency. We studied OSHPD data from 1995-1999. In cases where OSHPD information did not help to resolve a conflict, we made a decision based on our own best judgment.

FINDINGS

DISTRIBUTION AND CHARACTERISTICS OF CLOSED HOSPITALS

Twenty-three hospitals closed in the six-year period studied, with the most closures in 1998, at seven, and the fewest in 1995, with one hospital ceasing operations that year. This is laid out in *Table 1*. We noted an acceleration in closures, with seven from 1995 to 1997, and 16 from 1998 to 2000. However, the average size of the hospitals that closed did not vary greatly: 111 beds in the first half, 123 beds in the second half.

Taken together, the number of beds eliminated by the 23 closures account for 3.3 percent of the total licensed beds and 3.6 percent of the total available beds statewide in 1999. This fact is illustrated in *Figure 2*. While that is a small amount at the state level, only an examination of the local communities where hospitals closed could reveal whether the loss of these hospitals affected the service needs of the residents. In some instances, alternate services could potentially be provided by other area hospitals and health care delivery systems such as outpatient surgery, emergency and diagnostic centers, and home health services. More research is needed in this regard.

The area around Los Angeles experienced the highest number of closures, with 11 hospitals shuttered. The San Diego area also sustained four closures, making southern California the region most affected, at 15 hospitals or 65 percent of closures. Central California also saw a significant number of hospitals close, with five. Three other closures took place in Northern California, and the Santa Maria and Tulare areas. Most hospital closures were in urban areas, with just four rural hospital closures – Calexico Hospital in Calexico, Bloss Memorial District Hospital in Atwater, Lindsay District Hospital in Lindsay and Del Puerto Hospital in Patterson. Nearly half of the hospitals that closed, including three of the rural ones, had fewer than 100 licensed beds. Looking at *Figure 3*, it appears that small hospitals expired more often than any other type. They did so more frequently from 1998 to 2000, when eight such hospitals closed, than from 1995 to 1997, when just three small hospitals closed.

⁶ The raw financial data used for our analysis is also available by contacting the Petris Center office at (510) 643-4100 or at the address listed in the front of this report.

The closed hospitals, and their year of closure, are:

Urban/for-profit

Valley Community Hospital (1999)
Washington Medical Center (1999)
Friendly Hills Regional Medical Center (1998)
North Hollywood Medical Center (1998)
South Bay Medical Center (1998)
Newhall Community Hospital (1998)
Woodruff Community Hospital (1997)
Harbor View Medical Center (1997)
Westside Hospital (1996)
Desert Palms Community Hospital (1996)
Columbia Westlake Medical Center (1996)

Urban/non-profit

Scripps Memorial Hospital East County (2000)
Kaiser Foundation Hospital, El Cajon⁷ (2000)
Long Beach Community Medical Center (2000)
Mercy American River Hospital (2000)
Martin Luther Hospital Medical Center (2000)
St. Louise Hospital (1999)
Sierra Community Hospital (1995)

Rural and/or government/district

Bloss Memorial District Hospital (1998)
Calexico Hospital (1998)
Del Puerto Hospital (1998)
Lindsay District Hospital (2000)
Stanislaus Medical Center (1997)

Nearly half of the hospitals that closed were for-profit enterprises. *Figure 4* shows 11 or 48% of closed hospitals falling into that category. Those closures were enacted by Tenet Healthcare Corp., Columbia/HCA, Paracelsus Healthcare Corp., Med Partners, Washington Hospital Inc. and Bienvenido B. Tan, MD. Though they dominated the group of closed hospitals, for-profits overall made up just 28 percent of the state's GAC hospitals in both 1996 and 1999, as shown in *Figure 5*.

⁷ The 2000 closure of Kaiser El Cajon is a semantic one, as that facility stopped offering inpatient services in 1995, but did not relinquish its hospital license until five years later. Furthermore, it is not included in the financial analysis, as Kaiser is exempt from providing financial information for individual hospitals to the Office of Statewide Health Planning and Development (OSHDPD). Therefore, throughout the report, the reader will note that at times we are able to discuss all 23 closed hospitals, and at other times only 22 of them.

Among non-profit hospitals, seven closures were carried out by private corporations, and five by government or district owners. Private non-profit corporations Catholic Healthcare West, Memorial Health Services, Kaiser Permanente, Scripps and Community Hospitals of Central California each closed hospitals during the period studied.

Tenet and Catholic Healthcare West

Though many entities closed California hospitals during the mid to late 1990s, two hospital systems – Tenet Healthcare Corp. and Catholic Healthcare West – were the most active.⁸

Tenet Healthcare Corp. was the biggest player, participating in at least five closures and bearing an association with three others during the period studied. Four of the facilities Tenet closed were acquired as part of that company's 1997 merger with OrNda Healthcorp: Harbor View Medical Center in San Diego, North Hollywood Medical Center in North Hollywood, Valley Community Hospital in Santa Maria and Woodruff Community Hospital in Long Beach. In each of those cases, a Tenet spokesman said that the hospitals closed due to low utilization.

In the case of Friendly Hills Regional Medical Center, the 1998 closure by owner MedPartners was described in a Tenet press release as the next step in a Southern California alliance of the two companies.⁹ The equipment from the closed hospital was purchased by Tenet, and Friendly Hills' former patients were transferred to two nearby Tenet hospitals.

Additionally, patients from Stanislaus Medical Center in Modesto were formally transferred to Tenet's Doctors Medical Center after the Stanislaus County Board of Supervisors closed the facility in 1997. That arrangement included a payment by Tenet of \$12 million to the county, and a promise to treat 2,000 indigent patients per year. But we do not know the extent, if any, of Tenet's involvement in the decision to close the Stanislaus facility.

Tenet does dispute, however, that it participated in the closure of South Bay Medical Center in Redondo Beach.¹⁰ That closure followed Tenet's 1998 withdrawal from a contract with Beach Cities Hospital District to manage the hospital, a job it had held since 1984. We were unable to decipher all the fine points of that contractual relationship, but note that OSHPD lists Tenet as that hospital's owner the year it closed.

Finally, Tenet's Doctors Medical Center Modesto also briefly managed Del Puerto Hospital in Patterson, prior to its closure. The 40-bed rural hospital closed in April 1998, six months after Tenet's Modesto hospital took over operations. However, it was the hospital district board, not Tenet, that voted to close the facility.¹¹

⁸ A third system, Columbia/HCA, also closed two hospitals between 1995 and 2000: Columbia Westlake Medical Center in Westlake Village and Westside Hospital in Los Angeles.

⁹ "MedPartners and Tenet HealthCare Complete Next Step in Southern California Alliance," Tenet press release, April 8, 1998.

¹⁰ Interview with Tenet spokesman Harry Anderson, January 23, 2001.

¹¹ "Hospital Closure to Hurt West Side," Donna Birch, Modesto Bee, March 27, 1998.

Catholic Healthcare West closed three hospitals during the period studied: St. Louise Hospital in Morgan Hill in 1999, and, in 2000, both Mercy American River in Carmichael and Long Beach Community Medical Center in Long Beach.¹²

Changes in Ownership

In terms of hospital history, we found that 10 of the closed hospitals had changed hands at least once in the three years prior to closure. The changes in ownership involved four hospitals that were acquired by Tenet after the OrNda merger, and two hospitals that were purchased by Catholic Healthcare West from UniHealth -- one of which was subsequently sold to Memorial Health Services. Another hospital switched owners from Universal Health Services to Columbia/HCA, while one other was owned first by CareMark, then by MedPartners. In two cases, we learned that the owner at closure was not the owner three years prior, but were unable to determine the name of the previous owner.

As we did not study all hospitals' ownership patterns, we do not know if these hospitals changed owners more often than hospitals that did not close, nor do we know if a change in ownership is an indicator that a closure situation is shaping up. This would be a good area for further study.¹³

At least two of the closed hospitals are currently for sale.¹⁴ An effort to discover whether hospital owners had sought to sell their hospitals rather than close them was largely unsuccessful. Hospital chain spokespeople were either unable or unwilling to provide details on this question. Given time constraints, we did not attempt to ascertain whether the independent and government/district hospitals had been put up for sale prior to closure.¹⁵ Further information about what function the closed hospitals now serve appears in the Current Use of Hospital Buildings and Land section on page 16.

Payer Mix

In a further effort to describe the closed hospitals, we also studied the mix of discharges and revenues from government payers they reported. We found that, as a group, the closed hospitals reliance on Medicare and MediCal patients and revenue did not differ greatly from the state's 1999 open general acute care (GAC) hospitals. This fact is illustrated in *Figure 6*.

¹² Also, the 2000 closure of Martin Luther Hospital Medical Center in Anaheim took place just one year after CHW sold the hospital to Memorial Health Services. However, a spokeswoman for MHS said that CHW was not involved in the decision to close that facility. (Communication from Gina Esparza, Anaheim Memorial Hospital, Feb. 1, 2001.)

¹³ For a comprehensive look at the ownership status of California hospitals, see "The Growth of Multihospital Firms in California," by Joanne Spetz, Shannon Mitchell, and Jean Ann Seago, *Health Affairs*, Vol. 19, No. 6, November/December 2000.

¹⁴ For sale hospitals include: Mercy American River in Carmichael and Scripps Memorial Hospital East County in El Cajon.

¹⁵ Very little information of this type surfaced in press reports and other public forums.

However, when we broke down the closed hospitals into three categories – for-profit, non-profit and government/district – some interesting distinctions emerged.¹⁶ These mainly highlight differences between private hospitals, in this case both for-profit and non-profit entities, and public hospitals, owned by the government or hospital district.

In the case of MediCal, public hospitals reported a much higher proportion of discharges and revenues than both their private counterparts and the state's 1999 open GAC hospitals. As shown in *Figure 7*, in the three years prior to closure, the public (government/district) hospitals' MediCal activity ranged from discharges of 40 percent to 20 percent, and revenues of 40 percent to 38 percent. By contrast, the private (for-profit and non-profit) hospitals reported MediCal discharges ranging from 15 percent to 7 percent and revenues ranging from 11 percent to 5 percent. Overall, the state's 1999 open general acute care (GAC) hospitals reported that MediCal composed 19 percent of their discharges and 17 percent of their revenue. This is a higher proportion than the private closed hospitals, but a lower proportion than the public closed hospitals.

Unlike MediCal, Medicare activity looked much the same among the closed hospitals, and as compared to the state's general acute care (GAC) hospitals in 1999. These similarities are shown in *Figure 8*. In terms of public-private differences, the data also shows that public hospitals' Medicare revenues were much lower proportionally than both their private counterparts and the state's 1999 open general acute care (GAC) hospitals.

We do not know if these differences are unique to closed hospitals, or would hold true for all hospitals so divided into the categories of for-profit, non-profit and government/district. But these data certainly raise important questions about the role of Medicare reimbursement in the closing of public hospitals and the volume of and compensation for MediCal treatment provided by closed private hospitals. These data provide fertile ground for further study.

¹⁶ These distinctions are based on averages for the three categories of hospitals. It should be noted that these averages were based on small sample sizes and the standard deviations were sizeable. In other words, there exists much variation among the individual hospitals in each category.

REASONS FOR CLOSURE

We found a theme of financial hardship present at each hospital closure for which we were able to learn a reason. To determine whether financial troubles were apparent at all the closed hospitals, we looked to the financial data that the hospitals reported to OSHPD. Indeed, that examination confirmed that each closed hospital was struggling financially prior to closure. In fact, nearly all of the state's general acute care hospitals showed signs of financial distress, but those that closed¹⁷ were performing worse even than the average.

What follows is a financial analysis of the closed hospitals, as a group, and how they compare to California's 1999 general acute care (GAC) hospitals.¹⁸ The main area we examined was profitability. In that effort, we highlight three key measures that shed light on how the hospitals were performing: reimbursements, income per bed and utilization.

FINANCIAL FACTORS¹⁹

Financial data for California general acute care (GAC) hospitals suggest that the industry is financially pressed. Operating margins (operating income divided by revenues) have been negative during the study period.²⁰ However, non-operating income, that is, income from non-patient care sources, buoyed the average total profit margin to 3.1 in 1999.²¹ As a group, the closed hospitals reported some of the worst financial indicators. For instance, while the state's hospitals have amassed debt at nearly twice the national average and maintain thin operating margins, the closed hospitals showed even lower margins and greater accumulation of debt.²²

Surely, financial considerations played a part in the decision to close each of the 23 hospitals. From the hospitals themselves and press accounts of closures, we were able to draw out three reasons commonly cited. Some simply said the hospital was losing money, and did not elaborate as to why, others pointed to declining reimbursements and/or low utilization.

¹⁷ Only 22 of the 23 closed hospitals reported financial data to the state of California. Kaiser hospitals are exempt from reporting these data.

¹⁸ California hospitals are required by law to report financial and utilization data to the California Office of Statewide Health Planning and Development (OSHPD).

¹⁹ For a more technical, detailed analysis, see Appendix A of this report.

²⁰ Operating income is a measure of a company's earning power from ongoing operations, equal to earnings before deduction of interest payments and income taxes. Revenues are sales, or the total amount of money collected for goods and services provided. In the hospital business, the operating margin is calculated as net income from operations divided by the sum of net patient revenue and other operating revenue. It is expressed as a percentage.

²¹ OSHPD annual disclosure reports, 1999.

²² "Costly Rules Pushing Hospitals Closer To Crisis," by Lisa Rapaport, Sacramento Bee, Dec 24, 2000.

Indeed, by these measures, each closed hospital performed poorly in the three years prior to closure, with a dramatic decline in the last year before closing.²³ There could be a number of explanations for this pattern. The most straightforward reason would be that the hospital is simply failing financially, bleeding more and more heavily up until death. That could certainly be true in some cases. Another reason could be that the announcement or rumor of imminent closure prompted health plans and doctors to seek contractual relationships elsewhere, sent nurses in search of other jobs and led patients to avoid the facility. Those actions could also be reflected in poor performance. It is also possible that hospitals targeted for closure by the management of a larger health care system would be deprived of system support or capital, or would drop certain services, as the system prepares to consolidate or move medical services elsewhere. In that case, the hospital's performance would surely suffer, and be reflected that way in the data we gathered.²⁴ There is also a realistic chance that the reliability of the reported data in the year just prior to closure was not of the same caliber as it would have been if the business were a going concern. We did not sort out the various reasons for the performances tracked here. Nonetheless, they paint a clear picture of hospitals struggling financially before they close.

The first measure examined, declining reimbursements, goes to the dwindling payments from Medicare and MediCal, many of which were predicated on the Balanced Budget Act of 1997. They also point to the ratcheting down of payments, in the form of capitation and tighter restrictions on covered procedures, introduced by managed care organizations. To measure this element, we studied net patient revenue per bed²⁵ for each of the closed hospitals, during the three years prior to closure. As shown in *Figure 9*, in the year just before closure, 86 percent of closed hospitals earned \$207,252 or less per bed in reimbursements, a position only 25% of the state's general acute care hospitals held during 1999. Two years prior to closure, 50 percent of closed hospitals were in this category.²⁶

Striking as those figures are, it is important to note that hospitals do not rely solely on revenue from patient care, as they also gain income from non-patient care sources. This fact is reflected by a slightly higher total profit margin. The median total profit margin for closed hospitals 3 years prior to closure is 0 percent, but the mean total profit margin rises, to 1.0 percent. Even so, the group of closed hospitals lags behind,

²³ Data one year prior to closure was particularly variable with very extreme outliers relative to GAC hospitals that were not closed. It is unknown whether the imminent closure of a hospital may have impacted the integrity of the financial reporting and therefore the reliability of the data and financial ratios.

²⁴ One concern with focusing on the income statement is that income statements are easily manipulated by management to distort the appearance of financial performance, according to Dr. Nancy Kane of Harvard School of Public Health (Department of Health and Hospitals, Boston Massachusetts, 1993). This issue applies particularly to hospitals that are members of chains. For example, hospitals can understate their income by removing non-operating revenues from their income statement, by diverting revenue-generating assets to the parent company. This point is discussed at greater length in Appendix A.

²⁵ Net patient revenue is a measure of reimbursement for patient services prior to expenses.

²⁶ Due to the expediency required for this report, it was necessary to make compromises in methodology. For example, data based on one, two and three years prior to closure include hospitals that ceased to report data sometime between 1995 and 1999. Therefore, data based on years prior to closure spans multiple calendar years.

with lower profit levels than those shown by all GAC hospitals in each of the years 1996-1999. Before closure, the picture worsens considerably. By one year prior to closure, the reported median profit margin had plummeted to below -20 percent. In fact, *Figure 10* shows that 77 percent of closed hospitals lost more than \$9,269 per bed in the year before they closed, compared to 25% of the state's general acute care hospitals in 1999.

Low utilization also has become a familiar trend. This development is tangled up in both managed care policies and technological advancements. From the managed care side, the emphasis on shorter hospital stays and more outpatient procedures has translated into lower volume at many hospitals. This trend is fed by technology, which has made possible the transformation of many surgical procedures from in to outpatient undertakings. It is a national phenomenon. For example, outpatient surgeries grew from 16.3 percent of those delivered at community hospitals nationwide in 1980 to 61.6 percent in 1998.²⁷

To measure utilization, we looked at patient days, and found that during the three years prior to closure 18 of 22²⁸ hospitals reported a decline in patient days ranging from 4% to more than 85%. *Figure 11* illustrates this trend.

Clearly, all of the stresses outlined here are reflective of the increasing pressures of the market. Managed care, technological developments, capitation and competition combine to push some hospitals out of business. Poor management may also have been at the root of some hospital failures. It is also possible that several of the hospitals that closed were too small to survive in a competitive market.

In addition to declining reimbursements and lower utilization, some of the closed hospitals also pointed to an increase in non-paying patients, an inability to secure referrals, lack of a primary care network attached to the hospital, tight competition in the area, or another hospital very close by as factors that led to closure. On top of that, Desert Palms Community Hospital also reported that its location on the San Andreas Fault contributed to the decision to close in 1996.

Financial Pressures: Past and Future

Throughout the 1990's, hospitals felt squeezed by both private and government payers. Private insurers, faced with increased health care inflation, changed their policies to provide lower reimbursements. The Balanced Budget Act of 1997 slashed payments for Medicare and Medicaid (MediCal) patients, which make up about half of hospitals' revenues. Some of those reductions subsequently have been reversed, however, with the December 2000 passage of a \$35 billion Balanced Budget Act relief package, about \$12 billion of which is destined to reach hospitals over the next five years.²⁹

²⁷ National Center for Health Statistics. "Health, United States, 2000, with Adolescent Health Chartbook," Hyattsville, MD: 2000.

²⁸ Kaiser El Cajon not included.

²⁹ The five-year, \$35 billion Balance Budget Act relief package is the second major piece of legislation to restore a portion of the approximately \$200 billion in government healthcare spending that was cut by 1997's Balanced Budget Act. About \$12 billion of the \$35 billion in givebacks will go to hospitals.

Hospitals have been challenged further by a variety of financial and operational strains including rising pharmaceutical and technology costs, nursing shortages and the burden some took on by purchasing physician groups. The cumulative impact of these pressures was reflected by California hospitals' eight bond downgrades and no upgrades in 1999. A recent Standard and Poor's report states that California's health care market will continue to experience low profits and volatility for several more years. Consequently, the deteriorating credit ratings on hospitals' bonds and other debt will be slow to recover.

Currently, hospitals are preparing to shell out an estimated \$24 billion on state-mandated earthquake compliance and another projected \$2.5 billion to meet federal privacy standards.³⁰ These undertakings could exacerbate their precarious situation. If hospitals must go to the bond market to finance earthquake retrofits, poor credit ratings would force them to offer higher interest rates to get buyers for their bonds, thereby further increasing their expenses.

Retrofit requirements are likely to lead to additional closures in areas where the market is over saturated and margins and bed use are low. Predictions of seismic-related closures range from 50 to 150 hospitals by 2008.³¹ Indeed, a recent report by the California Office of Statewide Health Planning and Development found that four out of 10 hospital buildings in the state pose a significant risk of collapse in a strong earthquake, a condition that must be corrected by 2013.³² It is not certain whether all of these hospitals will undertake the required retrofitting.³³ It may be that market and financial factors are likely to weigh more heavily on the decision to close or consolidate facilities than issues related to access to quality healthcare services.

"Congress Enacts BIPA; \$35 Billion in BBA Relief on the Way," *Healthcare Financial Management*, v55, n2 (Feb, 2001) :9.

³⁰ Rapaport, Sacramento Bee, Dec. 24, 2000.

³¹ October 23, 2000 letter to California Attorney General Bill Lockyer from Duane Dauner, president, California Healthcare Association.

³² "Hospitals at Risk in Big Quakes," Sabin Russell, *San Francisco Chronicle*, March 29, 2001.

³³ More information on this matter is forthcoming. The California Health Care Foundation awarded a grant to RAND Corporation to evaluate the seismic burden on California hospitals. This report is due on August 1, 2001. Interview with Elaine Batchlor, vice president, California Health Care Foundation, April 9, 2001.

PUBLIC REACTION

For all the hue and cry that hospital closures seem to generate, we found evidence in only seven cases of public reactions or objections to the decision to close. However, two such instances were strong enough to prompt an investigation by the Attorney General.

Catholic Healthcare West presided over the two most contested closures, as communities fought the eliminations of long-standing hospitals in Long Beach and Morgan Hill.³⁴ Objections focused on an increase in travel time to the next-nearest facility, a reduction in emergency services, concerns about regional capacity to meet health care needs and the possible loss of reproductive health services. Those in opposition to the closures also raised fundamental questions about whether CHW, a non-profit system, was misusing the assets dedicated to charitable purposes by closing the two hospitals.³⁵ The closures of St. Louise and Long Beach Community hospitals were so hotly debated that the Attorney General launched an investigation of the CHW system.

Neither of these closures has been put entirely to rest at the time of this writing. Resistance to the 1999 closure of St. Louise Hospital in Morgan Hill, where vigorous public outcry, including the mayor and health care union Local 250 of the Service Employees International Union, continues. CHW consolidated services offered at Morgan Hill to a newly acquired hospital in Gilroy, which it named St. Louise Regional Hospital. At present, it is not clear whether the original St. Louise hospital will remain closed.

Another controversial closure, the 2000 shut down of Long Beach Community Medical Center drew scathing public response, with multiple hearings and the participation of local legislators, fire, emergency and medical personnel and labor, including SEIU Local 399. The hospital closed in October, for financial reasons, according to CHW. But the story is not over yet. The city of Long Beach took possession of the hospital's land, and has leased it to a community-based group with plans to reopen the facility. As of January 2001, the new Community Hospital of Long Beach is planning to open in May 2001.

Also in 2000, CHW closed Mercy American River Hospital in Carmichael, transferring patients to Mercy San Juan Hospital in the same city. Though that decision was met with a public protest at hearings before Sacramento County officials, a CHW spokeswoman said that the closure, which had been planned since 1993, went smoothly.³⁶

But CHW hospitals were not the only ones to draw critique. The 1999 closure of Washington Medical Center in Culver City also raised hackles. Assemblyman Herb

³⁴ Long Beach Community Medical Center opened in 1924 as an independent community hospital, joined Health West in 1988, which became UniHealth and was acquired by CHW in 1998. St. Louise Hospital in Morgan Hill was built by the Daughters of Charity in 1989, and joined CHW in 1996. "Uncharitable: How Nonprofit Hospital Chains Threaten Community Hospitals," by Julio Mateo, Jr., Esq., January 2001, report prepared for Locals 250 and 399 of the Service Employees International Union.

³⁵ Mateo, January 2001.

³⁶ Interview with Jill Dryer, spokeswoman for Mercy Healthcare Sacramento, a division of Catholic Healthcare West, January 30, 2001.

Wesson (D-Culver City/Los Angeles) expressed outrage at the 48-hour notice of closure provided to the Department of Health Services by investor-owned Washington Hospital Inc. In that case, 16 patients in the hospital's skilled nursing facility were hastily transferred upon closure.

Other objections focused on specific issues. In the case of South Bay Medical Center in Redondo Beach, the ACLU challenged Tenet's 1998 plan to sell that hospital to an entity that would convert it into an outpatient facility that offered no reproductive health services.

Two other closures drew public attention that is difficult to evaluate given the limited information we have. The 1996 closure of Paracelsus Health Care Corp.'s Desert Palms Community Hospital in Palmdale was marked by the community with a 100-person flag-lowering ceremony on the facility's final day.

In a peculiar twist, the federal government awarded Scripps Memorial Hospital East County in El Cajon \$921,000 in January 2001 for seismic upgrades, despite the fact that the hospital closed in 2000. Rep. Duncan Hunter (R-El Cajon), who sought the funds, said he hoped it would encourage Scripps or another buyer to reopen the medical center. Scripps, however, did not accept the grant.³⁷

CURRENT USE OF HOSPITAL BUILDINGS AND LAND

We found sparse information for the current use of the closed hospitals' land and buildings, gathering data for just 11 sites. Five of those closed hospitals retain a medical purpose, three are in limbo and three others have adopted non-medical roles.

Each of the five hospitals that still deliver healthcare serves outpatients. Calexico Hospital is now a rural health center, administered by the city of El Centro's Medical Center. Kaiser El Cajon is an outpatient facility serving Kaiser San Diego members. Martin Luther Hospital is now a dialysis center operated by Gambro Dialysis. South Bay Medical Center was intended for use by medical offices, as well as a fitness center and community playing fields. North Hollywood Medical Center will soon be converted into an assisted living facility with some health services.

The three that remain in limbo are among the most recent to close. Though CHW sold St. Louise Hospital to San Jose Christian College, with a deed that forbids its use for medical purposes, the status of that sale is on hold because it conflicts with the city of Morgan Hill's zoning regulations. Also, the building that contained CHW's Long Beach Community Medical Center has returned to the city, and been leased to a group that hopes to reopen the facility as Community Hospital of Long Beach, but there are no guarantees that will happen. Scripps Memorial Hospital East County is currently for sale, though not for use as an inpatient facility.

Two of the closed hospitals are no longer associated with medical care delivery. Mercy American River is up for sale, but until a buyer comes forward it is being used to house administrative offices of Mercy Healthcare Sacramento, a division of Catholic Healthcare West. Sierra Community Hospital was sold in 1999 for transformation into a multi-use senior center by the Fresno-Madera Agency on Aging.

³⁷ Interview with Johanna Blevins, Scripps spokeswoman, April 5, 2001.

IMPACT AND LOCATION OF OTHER NEARBY HOSPITALS

As stated earlier, the impact of a hospital closure is a time consuming and complicated endeavor that this report did not attempt. Instead, we looked at the location of the remaining open hospitals after a hospital closure.

Only two closures removed all hospital service from a 15-mile radius: Desert Palms Community Hospital and Del Puerto Hospital. In two of the rural closures, the remaining hospitals graze the edge of that 15-mile circle: Bloss Memorial District Hospital and Calxico Hospital.

Overall, hospital closures were concentrated most heavily in the Los Angeles area, with 11, followed by Central California, with five, and San Diego, with four closures. Northern California, Tulare and Santa Maria each lost one hospital during the period studied. Most closed hospitals appear to have been nearby other hospitals. The six maps that follow depict the hospitals that closed, and the presence or absence of open hospitals within a 15-mile radius³⁸.

In terms of other impact, we found the following issues raised in some but not all closures: loss of reproductive health services, necessity to travel out of town for hospital care, formal arrangements made to serve patients of the closed hospital, loss of a community's only hospital and ongoing contractual arrangements that extended beyond closure (such as Tenet's commitment to continue to make payments to Beach Cities Hospital District, despite pulling out of the management of South Bay Medical Center). Again, it is hard to generalize about these topics, as no clear patterns emerged.

Finally, it is important to mention that hospital closures resulted in the loss of jobs. We found some evidence of this, though we did not set out to study it. For instance, the following job losses were reported: 235 at Desert Palms, 290 at Harbor View, 319 at Scripps, 93 at Stanislaus.

³⁸ This measure was chosen for expediency, and does not reflect a study of travel time or any other factor that could affect local residents' (either urban or rural) access to the remaining hospitals.

CONCLUSION

As the Attorney General, the Department of Health Services, the legislature, policy makers, hospital executives, physicians, labor leaders and the general public brace for what is expected to be an increasing number of California hospital closures in the near future, this report lays out important information about the 23 recent such closures experienced in the state.

We have learned that urban, southern California hospitals, located in close proximity to other hospitals, were the ones that most frequently closed over the six-year period, 1995-2000. We also saw an acceleration in closures, with more than twice as many taking place in the second half of the period studied, when 16 hospitals closed, as in the first, when seven closed. We discovered that hospitals with fewer than 100 licensed beds closed more often than any other type. In fact, the total number of hospital beds eliminated in the 23 closures represents 3.3 percent of the licensed hospital beds and 3.6 percent of the available hospital beds statewide in 1999.

The report also tells us that private entities closed more hospitals than the government, that more for-profit hospitals closed than non-profit, and that hospital chains were the most active closers during the mid to late 1990s. We also learned that close to half of the closed hospitals had recently changed owners.

We know too that financial hardship was the common reason cited by all the hospitals that closed, a claim which is supported by an examination of their financial performance. In each case, we found declining reimbursements, income per bed and utilization present prior to closure.

As hospitals closed, we saw several of the facilities retain a medical purpose, providing outpatient services of one kind or another. We also heard communities' concerns about extended travel time to the next-nearest hospital, reduction or elimination of services and strains on capacity, especially for emergency services. In two instances, the objections to closures raised fundamental questions about the hospital owner's focus on the bottom line over its commitment to the community. These issues were so grave that the Attorney General launched an investigation.

*AREAS FOR FURTHER STUDY*³⁹

-The whole impact question is still wide open. The effects – both positive and negative -- of hospital closures on the community, providers, other hospitals and health plans can be profound or negligible, but should be incorporated in any further study of this topic. It is a difficult task, with many methodological challenges. But that fact makes it no less important. For example, future research could take up the question of which special services were provided by closed hospitals, if they were redundant, lost or replaced upon closure. Another important consideration would be the effect on prices of health care services after a hospital closes. These are merely two of a myriad of factors that should be considered in an impact study.

-Another aspect we merely touched upon here was whether ownership changes act as an indicator of a hospital's future. With the climate of mergers and acquisitions in California's hospital market, this information could be a key predictor of where a hospital is headed.

-Site visits would help answer the question about what use currently is being made of the closed hospitals' land and buildings, if any.

-Local interviews and libraries would help to fill in the blanks on hospital history.

-Future research could look more extensively into the status of the remaining open hospitals within the 15-mile radius of a closed hospital. Answers to questions such as who owns those hospitals, what types of services do they provide, how easy or difficult is it for local residents to access them, and others, would provide a richer picture of the effects of the hospital closure on the local community.

-Additional research on the remaining surrounding hospitals also could look at the impact of the closure on those hospitals revenue, utilization and charity care services.

-Future research could study the impact that California hospital closures have had on the availability of reproductive health services in the state.

-Future research could examine more characteristics of the closed hospitals, such as whether they provided emergency services, trauma care, labor and delivery, burn units, etc.

-Future research could study the phenomenon of acute care hospitals that close after converting many beds to serve non-acute patients. This arose twice in this study, where we discovered that both Del Puerto Hospital and Lindsay District Hospital had devoted at least half of their beds to skilled nursing facility and long-term care patients, respectively.

³⁹ Special thanks to the members of the Attorney General's Charity Health Care Task Force for contributing several ideas to this section.

One could then view the impact of these closures as extending beyond the delivery of acute care, while also taking into account that the demand for that type of care may have been dwindling in the area, forcing these hospitals to adjust their bed distribution. We did not look into these issues here.

-Future research could examine the role of Medicare and MediCal discharges and revenue in the operation of closed for-profit, non-profit and government hospitals, as well as the impact of closure on those beneficiary populations specifically.

-Future research could expand the study to all California hospitals and seek to create the first statewide hospital health report. This work could start by depicting the financial and ownership status of each California hospital, and the communities and patients they serve. It could further make use of the comparative financial and ownership information developed to make a prognosis about which hospitals will be economically viable into the future, and which ones are vulnerable to closure, merger, absorption into a chain, or transformation into another type of facility, be it medical or not.