# Hospital mergers unwind as organizations clash

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BY ALEX KACIK

## BUSINESS STRATEGY

Hospital mergers and acquisitions are often imbued with the promise that they will transform healthcare. But executives spend less time on the process and consequences of unwinding if the deal sours.

Several notable hospital transactions have fallen apart over the past year, as the acquired hospital or system claims that expectations weren't met, cultures clashed, executive turnover disrupted operations, performance declined or the hospital's autonomy was stripped. The separations can drag operations for years as they divert resources from patient care.

"These unwinds have implications across nearly every facet of an organization's operations, from governance, to finance, to IT, to branding, to credit ratings," said Ian Spier, director of healthcare public finance at Wells Fargo Securities. "In some cases, they have to reestablish end-to-end administrative and back-office functions to facilitate and support care delivery—that can be quite complicated."

Newport Beach, Calif.-based Hoag Memorial Hospital Presbyterian and Renton, Wash.-based Providence are amid a legal battle to dismantle their 2013 merger as Hoag argues that Providence didn't hold up its end of their population health initiative. After being part of Ascension for 18 years, St. Mary's Healthcare in Amsterdam, N.Y., split from the St. Louis-based chain last year because St. Mary's said it has been paying more into Ascension than it was receiving.

Yakima (Wash.) Valley Memorial Hospital separated from Seattle-based Virginia Mason Medical Center last year after CHI Franciscan and Virginia Mason pursued a merger. Egg Harbor Township, N.J.-based AtlantiCare and Danville, Pa.-based Geisinger Health agreed to a divorce last year after both parties sued each other for breaching the terms of their 2015 agreement. The separation was complicated by $62.5 million that Geisinger invested in AtlantiCare.

"I'm surprised by how many people in similar situations have reached out to me. This is a conversation wanting to be had in the industry for a long time," said Robert Braithwaite, CEO of Hoag Memorial. "Some institutions, advisers and healthcare think tanks are talking about this counter trend to mergers and acquisitions and realize it needs further exploration and support."

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**Robert Braithwaite, CEO of Hoag Memorial Hospital Presbyterian**

**THAT WAS THEN…**

**St. Joseph Health** and **Hoag Memorial Hospital Presbyterian** announce plans to merge

**AUG. 15, 2012**

**"Our affiliation will introduce innovative care processes** that will improve clinical outcomes, reduce the overall cost of care, and enhance the healthcare experiences of all members of our community."

**Dr. Richard Afable,** then-president and CEO of Hoag Memorial

## …THIS IS NOW

**MAY 17, 2021**

**"Rather than getting closer to the community** and achieving our population health objectives, that vision got farther away. Providence's perspective is national and ours is in Orange County."

**Robert Braithwaite,** CEO of Hoag Memorial Presbyterian Hospital

## SHOW ME THE MONEY

Most hospitals that joined a larger system generated more revenue but didn't become more efficient, Modern Healthcare's analysis of Medicare cost reports from 2013 to 2019 shows.

Hoag Memorial Hospital, for instance, saw its estimated operating revenue per day increase 29.2% from 2015—two years after it merged with Providence—to 2019. But its average operating expenses per day rose 34.1% over that span, dropping its average operating income per day 19.3%. Meanwhile, its full-time equivalent employees per average occupied bed rose from 5.99 to 6.75 from 2015 to 2019.

Although Medicare cost reports do not capture all of a hospital's data, they can provide general estimates of financial health. Cost reports are audited by the hospitals, and not a third party like annual earnings reports. They exclude physician practice metrics and system-wide measures, among other data. Modern Healthcare used 2013 as a baseline because the Medicare cost reports' format changed that year.

Modern Healthcare's analysis supports other research that found mergers yield minimal cost savings. Supply chain spending, for instance, only dropped about 1.5% after hospitals merged, which represents only about 10% of what is typically claimed for a merger justification, according to a University of Pennsylvania Wharton School working paper that analyzed hospital supply purchase orders from 1,200 hospitals from 2009 to 2015.

"People are beginning to understand that mergers don't bring about cost reduction," said Lawton Robert Burns, professor of healthcare management at the Wharton School, who wasn't affiliated with the study, noting the recent decline in M&A transactions as executives are being more careful.

Acquired hospitals typically pay what's essentially a tax to support the system's central office, said Dan Higgins, a partner at Dentons who is legal counsel for Hoag. Ideally, those centralized support offices produce more efficiencies than their cost to maintain them, he said.

"We have been paying an enormous amount, and what are we relying on them for?" Higgins asked. "The answer is fundamentally nothing."

Providence frames it differently. Providence helped Hoag build up its medical group, diagnostics, ambulatory surgery centers, orthopedic services and mental health offerings, said Erik Wexler, president of operations and strategy for the 51-hosptial system's southern footprint. The system also deployed the Epic electronic health record platform across Hoag's network, he said.

"If someone says nothing in population health improved, that wasn't the case," Wexler said. "Their improvements in quality and patient satisfaction have exceeded their own care standards, which illustrates the benefits of being together."

The court proceedings won't change day- to-day operations with Hoag, Wexler said, lauding the hospital and its medical staff. But it may slow long-term initiatives, he said.

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**Erik Wexler, president of operations and strategy at Providence**

**Due-diligence considerations**

M&A advisers offered several recommendations on how to best handle proposed transactions:

**Transparency:** Hospital executives should tell their teams how organizational structures would change if the deal goes through, including direct reports and goals of department committees. They should also tell the community why they would merge and what would change.

**Unwinding provisions:** Include how assets would be divided in the event of a breakup to try keep matters out of the courts.

**Culture:** Identify cultural differences between the two organizations related to how they work with physicians, daily workflows and strategic goals, among other issues.

**Integration plan:** Set a timeline and process for integrating service lines, executive/staff positions, back-office operations, vendor/payer contracts and IT systems.

**Alternatives:** Explore strategic options like joint operating agreements that could yield many of the same efficiencies without a change of control.

Source: Modern Healthcare reporting

“It may slow down other innovative opportunities because the parties are waiting to learn about what the court feels,” Wexler said. A trial date is set for April 2022.

Higgins said the cultures didn’t align either.

Hoag requested to change bedside monitors so that it would alert the nurses station when vital signs were off, rather than wake the patient, Higgins said. Hoag couldn’t get Providence’s approval because it “wasn’t part of Providence’s program,” he claimed.

“It was one of a thousand pin pricks where the corporatized parent wouldn’t allow a financially well-endowed, fastmoving hospital to do what it needed at the physician level,” Higgins said.

“Decision-making was so far removed from the community, it was a hindrance to community care,” Braithwaite said. “There’s an undermining of the commitment to the level of service and quality for the purpose of strengthening the financials at Providence. It felt counter-directional and certainly counter-cultural.”

Wexler rebutted the claims that Providence stripped Hoag of its authority, saying that “nothing could be further in the truth.” There are corporate offices in Irvine, he noted, adding that it is “really unfortunate Hoag is trying to pull apart a system of care that’s all within a 20-mile radius.”

Providence acquired St. Joseph Health in 2016. At that point, all of Providence’s focus was on improving St. Joseph’s financials and it tabled its population health initiative with Hoag, Braithwaite said.

Providence’s operating income declined $536 million from 2015 to 2016, posting 1.4% and -1.2% operating margins, respectively. The group of Orange County, Calif., hospitals, including Hoag, helped mitigate losses incurred at Seattle’s Swedish Health— which Providence acquired in 2012—and Providence’s Los Angeles operations. Hoag’s operating margin exceeded 5% from 2015 to 2019, according to the Office of Statewide Health Planning and Development data. Southern California represents more than 30% of Providence’s operating revenue. That share increased from 29% in 2018 to 32% in 2020.

Hoag accounts for less than 6% of Providence’s operating revenue, Providence said in its 2020 earnings report. But that’s an oversimplification, said Nathan Kaufman, founder and managing director of the healthcare consultancy Kaufman Strategic Advisors.

“Hoag is such a significant part of Providence’s financial performance, but they don’t have a say commensurate with that,” he said.

### SIZING UP SCALE

Expense growth outpaced or mirrored revenue growth at three of the four hospitals

## THAT WAS THEN…

**AtlantiCare** and **Geisinger** sign a definitive agreement to merge

**May 27, 2014**

**“Geisinger is a national model for innovation and value** that is on the leading edge of transforming healthcare, and we are pleased and excited to enter into this definitive agreement,”‘

**David Tilton,** then-president and CEO of AtlantiCare

## …THIS IS NOW

**Jan. 23, 2020**

**"Michael Charlton, AtlantiCare's chairman** and a member of Geisinger's board, breached his fiduciary duty to Geisinger and was aided and abetted by AtlantiCare's CEO, Lori Herndon."

**Geisinger** alleged in a complaint filed in a Pennsylvania federal court

Modern Healthcare analyzed to try to gauge why they sought to leave their parent systems.

"These systems are not put together to really cut costs or improve quality or for other reasons that CEOs explicitly say," said Wharton's Burns. "They are put together to grow."

St. Mary's Healthcare increased its average estimated operating revenue per day 25.4% from 2013 to 2019 while still a part of Ascension. But its operating expenses rose 32.2% over that span.

AtlantiCare Regional Medical Center, the health system's flagship hospital, was the exception. The estimated operating revenue per patient day was nearly double its expense growth from 2013 to 2019, increasing 26.4% and 14.9%, respectively.

Yakima Valley Memorial, which separated from Virginia Mason Medical Center last year after CommonSpirit Health's CHI Franciscan and Virginia Mason pursued a merger, saw its estimated operating revenue per day grow 47.9% from 2013 to 2019, falling short of its 71.9% increase in expenses.

"One reason for dissolution of some mergers is about access to reproductive services when the parent (company) is affiliated with a Catholic health system. Clearly, that was a factor in Yakima Valley and potentially one with Hoag," said Bill Kramer, executive director for health policy at the Purchaser Business Group on Health.

Looking further back, the $1.3 billion bankruptcy of Allegheny Health, Education and Research Foundation in July 1998 was, at the time, the nation's largest not-forprofit dismantling. The system, which grew from $195 million in revenue in 1986 to $2.1 billion in 1997, became overleveraged as it picked off a series of horizontal and vertical deals while reimbursement from major payers contracted. University of Pennsylvania Medical Center pulled some residencies out of Allegheny as a defensive strategy, which compounded matters. The rift between now-Highmark Health and UPMC persisted for decades.

"We are a trendy industry and people bought the value-based care myth, the population health myth and the scale myth," Kaufman said. "When you add the conflict of many of the advisers making money on these deals, you end up with this stuff."

UC San Francisco and Stanford merged in 1997, expecting to yield $256 million in savings over three years by pooling resources and increasing bargaining power. Instead, the combined entity lost $86 million in 1999, when the merger officially dissolved. Executives blamed lower reimbursement levels and culture mismatches.

“You could say that failed deal catalyzed Sutter (Health),” said Jeff Goldsmith, founder and president of healthcare consultancy Health Futures. “Markets were permanently altered.”

A report that Goldsmith co-authored when he was at Guidehouse found that scale didn’t guarantee better financial results. Some of the largest hospitals’ expenses grew by 3 percentage points faster than their revenue from 2015 to 2017, according to the consulting firm’s analysis of 104 highly rated health systems. That led to a combined $6.8 billion erosion of earnings, a 44% reduction.

“These big deals are really fragile because they rest on such a narrow political base,” Goldsmith said. “If there are not tangible benefits to the clinical workforce, middle management and patients, stress arises and the organization cracks.”

Politics, egos and operational efficiency can all get in the way. There is often significant internal and external pushback when jobs or services are cut. Some doctors or executives refuse to budge. Systems may lack the expertise to properly identify what needs to be consolidated.

“One of the biggest things that does not happen is consolidating services,” said Lyndean Brick, CEO of healthcare consultancy Advis. “When you are unwilling to do that, you are not going to improve quality and cost. That can absolutely be a tipping point.”

Blaming culture is a convenient, and ambiguous, curtain to hide behind, Brick said.

“It means we didn’t do things that we could’ve done like eliminate redundant executives to lower costs,” she said. “Certainly a lot of ego is involved, which can be the undoing, although it’s never the stated reason.”

Unwinding provisions in final M&A agreements are becoming more common as executives see other mergers fail. There will be “out clauses” related to certain unmet performance or financial thresholds. But they are relatively rare, and certainly not in every merger agreement, observers said.

“There is the thrill of the kill of getting to the finish line and not a lot of attention is spent on integration,” said John Washlick, a shareholder at the law firm Buchanon Ingersoll & Rooney. “There have been situations where I asked for an integration plan, and it was never produced.”

## HARD TO UNWIND

Mergers are inherently disruptive. Executives often wait to disclose they are discussing a merger because it triggers job security concerns. But the lack of transparency can also cause anxiety.

“It’s almost like, ‘we’ll deal with that when we get there.’ Then they get there, and all these problems are brewing and fester in each separate hospital,” Washlick said.

More deals are coordinated largely between CEOs, even when management teams and governing boards are less enthusiastic about the transaction, experts said.

“Post-transaction decision-making is a critical aspect of all these mergers,” said John Fanburg, chair of healthcare law at Brach Eichler, adding that the smaller hospital or system’s control is often muted. “There’s an economic incentive to hear what they have to say, but ‘it’s our money and we call the shots.’ ”

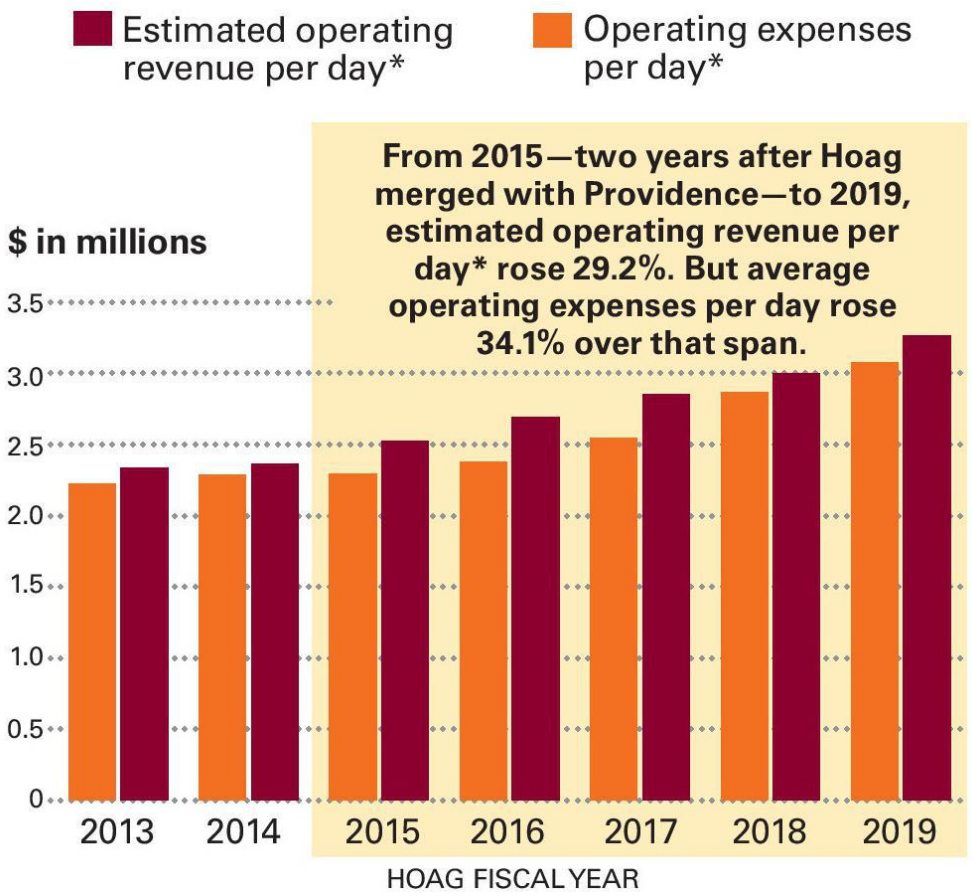
By design, merger agreements can make it very painful and create significant disincentives to unwind the relationship, Wells Fargo’s Spier said.

“If you make the off-ramp too easy, you may never achieve initial integration,” he said. “It may be a combination in appearance only.”

## MERGER INDIGESTION

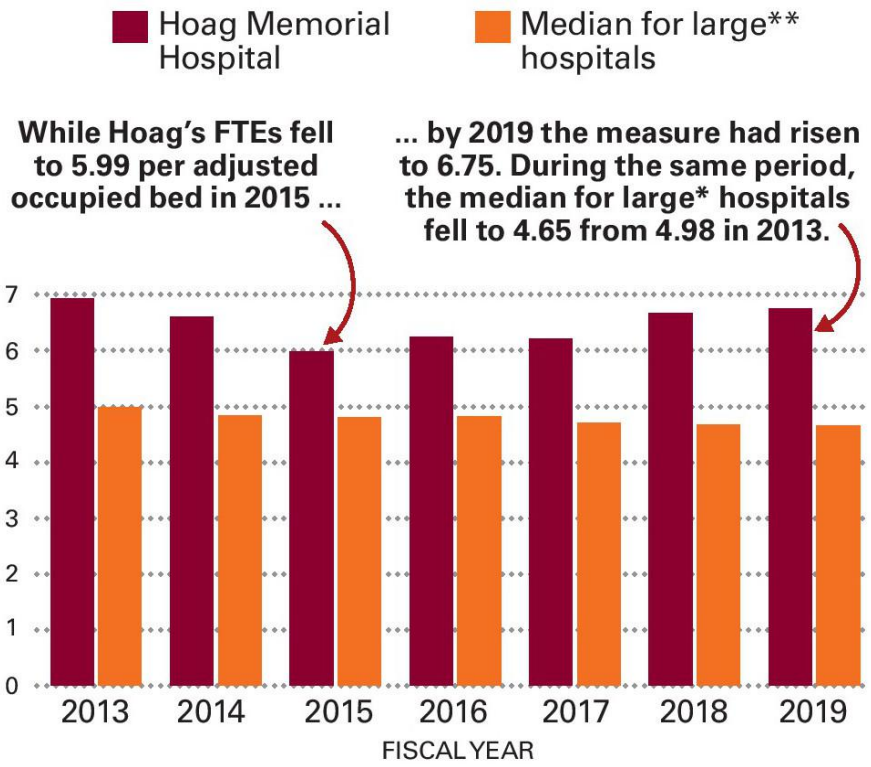
Hoag Memorial Hospital Presbyterian and Providence hoped scale would yield synergies. But after the merger, expenses kept pace with operating revenue, and labor costs proved difficult to control.

## REVENUE VS. EXPENSES




* Average per day in the reported fiscal year

## FTEs PER ADJUSTED OCCUPIED BED



** Large = non-teaching acute-care hospitals with more than 250 acute care beds

## Notes

Estimated operating revenue from cost reports is derived from a formula created by Healthcare Management Partners with Modern Healthcare: net patient revenue + (other income – (contributions + investments + government appropriations)).

FTe per adjusted occupied bed calculated using a formula from the Flex Monitoring Team, flexmonitoring.org

Source: Data is from CMS cost reports, which are self reported by systems and hospitals

**“Folks are seeking a model that allows them to achieve many or most of their strategic goals without necessarily fully integrating or ceding control.”**

**Ian Spier, director of healthcare public finance at Wells Fargo Securities**

Hospital executives continue to point to “synergies” to justify mergers.

A study commissioned in 2019 by the American Hospital Association found that acquired hospitals saw a 2.3% reduction in operating expense per admission from 2009 to 2017. Although academics questioned the integrity of the study, pointing to evidence to the contrary.

In a presentation for the J.P. Morgan Healthcare Conference in January 2019, Baylor Scott & White said its 2013 merger between Baylor Health Care System and Scott & White Healthcare has resulted in more than $700 million in savings— exceeding its $657 million target. The bulk stemmed from supply chain followed by managed care. Still, research shows, savings don’t often translate to lower prices.

“Economists always say that consolidation results in higher prices. The answer is, you bet,” Kaufman said. “But without the higher prices, certain hospitals probably wouldn’t have survived or retained their doctors—that’s the other side of the equation.”

## M&A REBOUND

Even though some deals are unwinding, they aren’t expected to meaningfully slow M&A activity. Pent-up demand from a relatively quiet 2020 is expected to boost hospital transactions this year and into 2022, industry observers said.

There were only 79 announced hospital deals in 2020, partly due to the COVID-19 pandemic, Ponder & Co. found. That was down 25% from the trailing 10-year average and the lowest annual tally since 2009, although volume rebounded in the fourth quarter. Still, the number of deals that are unwound pale in comparison to the announced transactions every year.

Scale is still seen as a defensive strategy, potentially insulating systems from growing competitors and unexpected emergencies.

“Merger mania continues on,” Fanburg said. “People should learn from the failed relationships, but people are still talking.”

Fitch Ratings expects more mergers over the next two years, said Kevin Holloran, senior director at the ratings agency. Scale helped organizations weather the pandemic as they shifted resources based on demand and had more cash on hand, he said.

But key members of the Biden administration have historically been tough on hospital mergers, particularly Vice President Kamala Harris and HHS Secretary Xavier Becerra when they served as California attorneys general. Bills are moving through Congress as well as the states that would bolster regulatory oversight of hospital deals and hospital acquisitions of physician practices.

That could be part of the drive behind a renewed interest in joint operating agreements, Spier said. More are taking the place of fully integrated membership substitutions, he said.

“Folks are seeking a model that allows them to achieve many or most of their strategic goals without necessarily fully integrating or ceding control,” Spier said, adding that a joint operating agreement can result in 80% to 90% of the benefits of full integration while adding some flexibility. “If you align incentives and ensure both parties have skin in the game, a joint operating agreement can be an effective form of partnership.”

As health systems pitch mergers, executives should take note of the ones that have failed, M&A experts said.

They recommended increased transparency, sharing how potential transactions would impact operations as well as the surrounding community. Prepare for unwinding in the due-diligence process. Identify cultural differences and establish concrete steps to integrate.

But for some deals already consummated, the writing is on the wall, Kaufman said.

More CEOs are waking up to the fact that they would’ve been better off independent, and that the pricing and access to capital benefits that accompany consolidation aren’t as important, he said.

“There are a lot of disgruntled system CEOs, especially in the not-for-profit sector, that feel disenfranchised,” Kaufman said.