

Department of Health and Human Services
**OFFICE OF
INSPECTOR GENERAL**

**THE EFFECTS OF HOSPITAL MERGERS
ON THE AVAILABILITY OF SERVICES**

A Case Study of Eight Hospital Mergers



Richard P. Kusserow
INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

This report describes the effects on the availability of hospital services when hospitals merge.

This report contains a case-by-case description of the eight mergers in the study sample.

A report entitled "The Effects of Hospital Mergers on the Availability of Services" (OEI-04-90-02400) was issued at the same time as this report. That report is a summary, based on findings, of the hospital mergers in the study sample.

BACKGROUND

Changes in Medicare hospital reimbursement and other "belt-tightening" actions by public and private payers have forced hospitals to operate more efficiently. Among the cost-cutting measures considered by hospitals are resource-sharing arrangements and consolidation. Some hospitals conclude that merger is the best course to remain viable.

The U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC), however, maintain that mergers may, in some situations, reduce healthy competition. It is their responsibility to protect consumers from anti-competitive actions which may result in higher prices and restricted choices. The DOJ prepared the Federal Merger Guidelines ("Guidelines") in 1968. The DOJ uses the Guidelines to determine which proposed mergers may violate antitrust law. The FTC uses the Guidelines and other criteria for their merger analyses. The Guidelines do not mention the hospital industry specifically, nor issues of access to care.

Some members of the hospital industry are deeply concerned about DOJ's and FTC's increased interest in and challenge to hospital mergers in the past few years. Recent antitrust suits have caused a great deal of consternation in the industry and have complicated the decision-making process for hospitals considering merger. On the other hand, figures from the American Hospital Association indicate that 40 to 60 mergers (the term includes acquisitions) have occurred annually in the past decade. The DOJ and FTC have brought fewer than 10 antitrust cases against hospitals during that time.

In November 1989, Secretary Sullivan appointed a task force to examine hospital merger issues and asked the Inspector General to conduct certain studies to support the work of the task force. This report assesses the effects of hospital mergers on the availability of hospital services.

FINDINGS

This assessment of eight hospital mergers found that:

- In all cases, one or both of the merging hospitals suffered from declining occupancy, lagging revenues, and/or rising costs. The mergers addressed these problems; all of the remaining hospitals are reported to be stronger as a result of merger.
- None of these mergers drew community opposition, and none were challenged by antitrust enforcement agencies.
- Of the 16 merging hospitals, four closed (ceased to provide general acute care) after the merger.
- No negative effects on the availability of hospital services resulted from any of the mergers. In all eight merger cases, the availability of hospital services was maintained or improved.

RECOMMENDATIONS

This report contains no recommendations. However, the HHS Hospital Merger Task Force may make recommendations based on these and other studies.

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INTRODUCTION

PURPOSE

This report describes the effects on the availability of hospital services when hospitals merge.

The Secretary of the U.S. Department of Health and Human Services (HHS) requested this inspection.

This report contains a case-by-case description of the eight mergers in the study sample.

A report entitled "The Effects of Hospital Mergers on the Availability of Services" (OEI-04-90-02400) was also issued at the same time as this report. That report is a summary, based on findings, of the hospital mergers in the study sample.

BACKGROUND

Observers of the health care industry note the dramatic changes in that industry in recent years, including an increase in the number of mergers. One independent surveyor has forecast that the number of hospitals in multi-hospital systems will increase from about 2,400 in 1986 to over 3,400 by 1995.¹

Changes in Medicare hospital reimbursement and other "belt-tightening" actions by public and private payers have forced hospitals to operate more efficiently. Among the cost-cutting measures considered by hospitals are resource-sharing arrangements and consolidation. Some hospitals conclude that merger is the best course to remain viable.

The U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC), however, maintain that mergers may, in some situations, reduce healthy competition. It is their responsibility to protect consumers from anti-competitive actions which may result in higher prices and restricted choices. The DOJ prepared the Federal Merger Guidelines ("Guidelines") in 1968. The DOJ uses the Guidelines to determine which proposed mergers may violate antitrust law. The FTC uses the Guidelines and other criteria for their merger analyses. The criteria in the Guidelines take into account the geographic market, the product market, the market shares of each merging entity, the effects of competition on prices, imminent financial failure, and efficiencies to be gained through merger. The Guidelines do not mention the hospital industry specifically, nor issues of access to care.

Some members of the hospital industry are deeply concerned about DOJ's and FTC's increased interest in and challenges to hospital mergers in the past few years. Recent antitrust suits have caused a great deal of consternation in the industry and have complicated the decision-making process for hospitals considering merger.² On the other hand, figures from the American Hospital Association indicate that 40 to 60 mergers (the term includes acquisitions) have occurred annually in the past decade. The DOJ and FTC have brought fewer than 10 antitrust cases against hospitals during that time.³

In November 1989, Secretary Sullivan appointed a task force to examine hospital merger issues and asked the Inspector General to conduct certain studies to support the work of the task force. This report assesses the effects of hospital mergers on the availability of hospital services.

SCOPE

The study examined eight cases of hospital merger that occurred during 1987.

For purposes of this study, the term *merger* includes acquisition. A *hospital* is defined as a facility that provides general, short-term acute medical and surgical inpatient services.

METHODOLOGY

In selecting the eight mergers for the case studies, we began with the American Hospital Association's (AHA) list of 1987 mergers. The AHA list contained 20 mergers that met the study criteria. From this list we identified:

- ▶ rural general acute care hospital mergers where both hospitals were located in the same county, and
- ▶ urban general acute care hospital mergers where both hospitals were located in the same Metropolitan Statistical Area (MSA).

We selected four mergers from each group.

We conducted on-site visits to each community in the eight case studies. The study team obtained information from hospital administrators and staff, hospital board members, business leaders, local physicians, other local health care providers, local public officials, concerned citizens, State hospital associations, and State health planning agencies.

This study examined on the pre-merger versus the post-merger availability of hospital and related health care services. To ascertain the effect of the merger on availability, the pre-merger services offered by both merger partners were compared to the services still offered by the post-merger facility. If a service was deleted as a result of the merger, the study team ascertained the availability of that service from another provider, and the distance to that provider.

We did not analyze the broader and more complex issue of access to care that would have required examination of a number of factors beyond the scope of our review, such as: the availability or adequacy of health insurance coverage; patient and physician preferences to use a particular hospital; and the availability of related health care services in the area served by a hospital.

RECOMMENDATIONS

This report contains no recommendations. However, the HHS Hospital Merger Task Force may make recommendations based on these and other studies.

CASE STUDIES

The following is a case-by-case description, based on discussions with respondents, of the eight mergers in the study sample.

***Ottumwa Regional Health Center
Ottumwa, IA***

***St. Joseph Health and
Rehabilitation Center
Ottumwa, IA***

merged into

**OTTUMWA REGIONAL HEALTH CENTER
OTTUMWA, IA**

WHAT WERE THE HOSPITALS LIKE BEFORE AND AFTER THE MERGER?

Prior to the merger there were two hospitals approximately 1.5 miles apart serving approximately 25,000 residents of Ottumwa, Iowa. They were Ottumwa Regional Health Center, the 183-bed community hospital, and religiously-affiliated St. Joseph Health and Rehabilitation Center (“St. Joseph’s”), with 82 beds. Both were general acute care hospitals.

Many years prior to the merger the two hospitals had agreed that St. Joseph’s would focus on substance abuse, while Ottumwa Regional Hospital would perform most of the obstetrical, gynecological and pre-natal services. However, according to respondents, the hospitals were beginning to compete with each other by duplicating many services.

A few years before the merger, Ottumwa Regional Hospital formed a venture capital company called Ottumwa Regional Venture, Inc., which served as a holding company for the hospital and other for-profit enterprises. In 1987, after lengthy negotiations, the owners of St. Joseph’s, the Sisters of Humility, sold the hospital to Ottumwa Regional Venture, Inc. Ottumwa Regional Hospital and St. Joseph’s were merged to form Ottumwa Regional Health Center. St. Joseph’s was closed as an acute care hospital and became the site for an outpatient services center. Ottumwa Regional Health Center now operates 237 acute care beds.

WHAT WERE THE PROBLEMS AND WHY DID THEY MERGE?

Most respondents said they realized that the community could not support two acute care hospitals. The hospitals were being drained financially by competing with each other for patients and duplicating expensive equipment. Revenues were decreasing due to reduced reimbursements, declining admissions, and shorter stays. Ottumwa Regional Health Center was designated a Regional Referral Center, but was reportedly in danger of losing this designation if its patient mix did not increase.

Respondents said they feared that if the decline continued, both hospitals would be forced to close. The merger was a way to address these problems and improve the capital position of the surviving hospital.

WAS THE MERGER CHALLENGED?

No one formally opposed the merger. During the negotiation period, a committee was established with representation from the medical community as well as both hospitals to look at the community's health care needs. All of St. Joseph's personnel were offered jobs and were able to retain their seniority. The physicians had admitting privileges at both hospitals. Several physicians said they supported the merger because of the potential increases in efficiency.

The FTC informally inquired into the merger, but did not challenge it.

DID THE MERGER AFFECT THE AVAILABILITY OF HOSPITAL SERVICES?

The availability of inpatient services was unaffected by the merger. Although St. Joseph's closed as an acute care hospital, the distance to Ottumwa Regional Health Center is approximately 1.5 miles and both are on the same bus route. After the closure of the emergency room at St. Joseph's, it was reported by one respondent that patients seeking emergency treatment had slightly longer waits. No services were deleted as a result of the merger.

The availability of outpatient services has improved since the merger. An extracorporeal shock wave lithotripter and a magnetic resonance imager have been purchased. A free-standing blood bank has been added.

Ottumwa Regional Health Center continues to offer alcohol and chemical rehabilitation services at the St. Joseph's location. The building provided space to add services such as an adult daycare center, respite care, mental health and psychological services, home health care and hospice service.

*Axtell Christian Hospital
Newton, KS*

*Bethel Deaconess Hospital
Newton, KS*

merged into

**NEWTON MEDICAL CENTER
NEWTON, KS**

WHAT WERE THE HOSPITALS LIKE BEFORE AND AFTER THE MERGER?

Prior to the merger there were two competing general acute care hospitals in Newton, Kansas. Bethel Deaconess Hospital (“Bethel”) operated 90 beds, and Axtell Christian Hospital (“Axtell”) operated 32 beds approximately one mile away. Bethel offered a few more services than Axtell, but in general they provided similar primary health care services. They competed with each other for Registered Nurse staff, physician referrals, patients, and the procurement of advanced medical equipment.

Both hospitals were private, not-for-profit institutions with religious affiliations: Bethel with the Mennonite Church and Axtell with the United Church of Christ. Both hospitals served Medicare and Medicaid patients and provided charity care to persons unable to pay. They were governed by separate boards comprised of lay people and representatives from their respective churches.

The two hospitals served the residents of Newton (population 16,500) and Harvey County (population 30,000 to 32,000), which had a stable economy based on agriculture, farm implement manufacturing, rail transportation, health care, and aircraft manufacturing in Wichita, 25 miles away. The only other general acute care hospital in the area is Halstead Hospital in Halstead, Kansas, a 190-bed hospital approximately 10 miles from Newton. Halstead Hospital, a secondary and tertiary level referral center for Western Kansas, is not considered a competitor, according to respondents.

The original merger plans were to consolidate the two parent hospitals into Newton Medical Center but to keep both physical locations open until a new facility could be built which would house the combined institutions. Six months into the merger it became apparent that this was not economically feasible. The Axtell facility was closed.

Newton Medical Center, which is not religiously affiliated, is now housed in the location which was formerly Bethel. Newton Medical Center is a 72-bed hospital owned by Newton Healthcare Corporation, a private, not-for-profit corporation. Newton Healthcare Corporation also owns Harvey County Home Health and two for-profit corporations, and maintains its offices in Newton Medical Center. The majority of the patients who had been served by Axtell and most of the Axtell physicians moved to the Bethel location. A Board of Directors comprised of 19 lay people governs the hospital.

WHAT WERE THE PROBLEMS AND WHY DID THEY MERGE?

A merger between the two hospitals had been discussed and analyzed for some years prior to 1987. Since the early 1980's the community and the two hospitals knew that they were overbedded and that competing with each other was creating costly duplications of services and equipment. In 1981 a committee was formed to discuss merging. At that time the resistance was too great, the idea was tabled, and the committee inactivated.

Around 1985 both hospitals were suffering from decreasing occupancy, shorter stays per patient, and a general downward trend financially. Other problems were a shortage of Registered Nurses and some difficulty in finding specialists. At that time the merger committee was reactivated, and the merger was planned. The merger was officially accomplished on July 17, 1987, and operationally effective on January 1, 1988.

Most of the pre-merger problems were addressed by the merger, although there is still a shortage of Registered Nurses. Competition for Registered Nurses is fierce, particularly due to Newton's proximity to Wichita where higher pay is offered.

WAS THE MERGER CHALLENGED?

The promise of a new hospital at a new location made the merger and the subsequent closure of Axtell more palatable. Despite the promise there was some resistance to the merger, particularly on the part of physicians who had practiced at Axtell. Some sense of loss was felt by the community, but no serious resistance came from any corner of the community. The community continues to be supportive of Newton Medical Center.

The other problem was a statutory prohibition to licensing two physical facilities under one license. The Kansas State Legislature passed enabling legislation which eliminated this obstacle. No antitrust enforcement agency challenged the merger.

DID THE MERGER AFFECT THE AVAILABILITY OF HOSPITAL SERVICES?

The availability of services has not been affected adversely by the merger. No pre-merger services were deleted. Availability has been improved by adding health promotion services, an in-house computed tomographic (CT) scanner, and by upgrading the nursery from a Level I (well baby) to a Level II (intermediate care) facility.

Medicare and Medicaid patients continue to be served, and no policy or procedural changes have occurred regarding care for charity cases. Patients who formerly went to Axtell and who lived near Axtell have to travel approximately 1 mile further to Newton Medical Center.

*Samaritan Health Center
Detroit, MI*

*Mount Carmel Mercy Hospital
Detroit, MI*

merged into

MERCY HOSPITALS AND HEALTH SERVICES OF DETROIT DETROIT, MI

WHAT WERE THE HOSPITALS LIKE BEFORE AND AFTER THE MERGER?

Prior to the merger there were two hospitals in Detroit, Michigan which were divisions of the Sisters of Mercy Health Corporation. They were 451-bed Mt. Carmel Mercy Hospital ("Mt. Carmel") in Northwest Detroit, and 236-bed Samaritan Health Center ("Samaritan") in East Detroit. Both hospitals served the inner city residents of Detroit, a predominantly lower socio-economic, black population.

Mt. Carmel provided tertiary level care and Samaritan provided secondary level care. Both hospitals were led by a governing board comprised of lay, religious, and medical people. Both had its own CEO and a full complement of managerial staff.

Sisters of Mercy Health Corporation, a not-for-profit subsidiary corporation of Mercy Health Services, owns 23 hospitals and six outpatient clinics. Mercy Health Services is a not-for-profit Michigan corporation sponsored by the Sisters of Mercy of the Province of Detroit who are dedicated to providing health care to people in need, giving priority to those who are economically disadvantaged. The other subsidiaries of Mercy Health Services are a home health care agency, an alternative financing system, 20 retirement living and long-term care facilities, a foundation for fund development, an information systems division and an insurance company.

The two Detroit hospitals and the six outpatient clinics merged management and governance structures on August 1, 1987, to become Mercy Hospitals and Health Services of Detroit. The hospitals maintained their own physical plants and their respective names.

WHAT WERE THE PROBLEMS AND WHY DID THEY MERGE?

In 1987 the MSA of Detroit, with a population of approximately 5 million, was recovering somewhat from the economic slump in the automobile industry. The inner city, with a population of around 1 million, was experiencing an ongoing decline. Middle income people continued to migrate to the suburbs and the remaining population was plagued by rising unemployment, a high infant mortality rate, and increasing drug and education problems.

As the population served by both hospitals became increasingly indigent, and as paying patients became fewer and fewer, these two facilities created an ever-increasing drain on the total system. In addition to the demographic changes and their accompanying impact on patient mix, all hospitals in the tri-county area of Detroit were faced with high liability insurance premiums. The cost of liability insurance in Detroit is estimated to be six to seven times the national average, and is among the highest in the nation.

Samaritan's situation was exacerbated by its loss of patients and physicians in the 9 years prior to this merger. In 1978 Samaritan, known then as St. Joseph Mercy Hospital, and Evangelical Deaconess Hospital merged at the management level, but maintained their own physical plants. In 1983 St. Joseph Mercy Hospital moved to the old Detroit Receiving Hospital, losing patients and physicians in the aftermath. In 1984 both St. Joseph Mercy Hospital and Evangelical Deaconess moved into the present physical facility and became Samaritan Health Center. Again, patients and physicians were lost. By 1987 Samaritan had lost all of its specialists except for one orthopedic surgeon.

By 1987 Mt. Carmel and Samaritan, but more so Samaritan with its larger indigent care base, had become constant financial drains on the system. Together they accounted for millions of dollars in losses each year. Corporate management decided to merge the two management teams, operational functions and governing boards. These changes would reduce both capital and operating costs; eliminate duplication and redundancy; increase market share; and expand and improve the ambulatory and primary care delivery system network. The combined hospitals would be more competitive in the Health Maintenance Organization (HMO) market. The stated thrust of the merger was to increase the number of patients belonging to HMO's and Preferred Provider Organizations, by offering a city-wide distribution of ambulatory and inpatient facilities. All of these improvements, ultimately, were geared towards reducing the financial drain on the corporate parent.

WAS THE MERGER CHALLENGED?

As far as the general public was concerned, nothing had changed, and they offered no resistance or opposition. According to most respondents there were negative reactions from within the two hospitals, particularly on the part of the physicians. As staff were terminated, anxiety over job security and the presence of new administrators and managers rose. The sense of separateness between the two medical staffs was heightened. No antitrust enforcement agency challenged the merger.

DID THE MERGER AFFECT THE AVAILABILITY OF HOSPITAL SERVICES?

The availability of services was unaffected by the merger. No changes were made in the medical services offered, and no intermingling of medical staffs occurred. Some respondents felt, however, that due to cutbacks in personnel, the level and possibly the quality of some services suffered. No services were deleted at that time. In late 1989 the pediatric inpatient unit at Samaritan closed due to low census. Samaritan's women's center also closed some time after the merger, but not for reasons associated with the merger.

The merger somewhat alleviated the financial drain the two hospitals were creating; however, the drain continued. In fiscal year 1989 the two facilities accounted for a combined loss of around \$28 million. In July of 1990 the 1987 merger of the management structures of these two facilities was nullified.

As of July 1, 1990, Mt. Carmel Mercy Hospital, although still a part of the Sisters of Mercy Health Corporation, was placed under the management of the Detroit Medical Center. Detroit Medical Center owns Grace Hospital and six other hospitals. Under the letter of intent which created the new management agreement, Detroit Medical Center will renovate Mt. Carmel to accommodate certain services such as obstetrics. The medical staffs and employee groups of Mt. Carmel and Grace Hospital will be consolidated into one organization to be housed at the Mt. Carmel location. Detroit Medical Center will assume ownership of Mt. Carmel on April 1, 1991.

As of July 1, 1990, the Sisters of Mercy Health Corporation entered into a joint venture agreement with Henry Ford Health Systems regarding Samaritan Health Center. Per the agreement, Henry Ford Health Systems will manage Samaritan under a five-year management contract, as well as provide "significant financial support" to Mercy Health Services. Henry Ford Health Systems' physicians will work with Samaritan's medical staff to provide care to the patients at the hospital and its six outpatient centers known as Mercy Family Care Centers. The president of the Sisters of Mercy Health Corporation said of the venture: "The involvement of Ford physicians will allow us to expand the services we currently offer and reach an even larger part of the underserved populations, which is consistent with the missions of the Religious Sisters of Mercy and Henry Ford Health Systems' Urban Health Initiative."

*Trinity Lutheran Hospital
Kansas City, MO*

*St. Mary's Hospital
Kansas City, MO*

merged into

**TRINITY LUTHERAN HOSPITAL
KANSAS CITY, MO**

WHAT WERE THE HOSPITALS LIKE BEFORE AND AFTER THE MERGER?

Prior to the merger there were two general acute care hospitals within 1 block of each other in Kansas City, Missouri: 253-bed Trinity Lutheran Hospital and 198-bed St. Mary's Hospital ("St. Mary's"). Trinity Lutheran Hospital provided mostly tertiary level care, and St. Mary's provided mostly general, primary level, family-practice services. They both served the area of Kansas City called "midtown."

Trinity Lutheran Hospital was owned by Trinity Health Systems, Inc., a not-for-profit corporation housed in Trinity Lutheran Hospital, and was run by a governing board comprised of community leaders and physicians. St. Mary's was owned and operated by the SSM Healthcare, in St. Louis, Missouri. The SSM Healthcare is a not-for-profit Missouri corporation sponsored by the Franciscan Sisters of Mary, and is guided by a lay advisory board. The pre-merger occupancy rate at Trinity Lutheran Hospital was 47 percent, with an average daily census of 119. The occupancy rate at St. Mary's was 45 percent, with an average daily census of 90.

The primary industries in Kansas City are marketing and shipping agricultural goods; manufacturing machinery, transportation equipment, steel, and chemicals; oil refining; automobile assembling; and printing and publishing. The MSA of Kansas City has a population of one and one half million. The population of Kansas City, Missouri alone is approximately 450,000.

The metropolitan area of Kansas City was growing economically. Midtown was comprised mainly of lower income, caucasian elderly subsisting on Social Security benefits, and a small Hispanic population. At one time the area was populated by middle income families, most of whom had migrated to the suburbs. Large hotel/convention complexes are being developed in and near midtown. The area is now beginning to attract middle income residents who are purchasing and renovating old homes.

The merger process began between the two hospitals in mid-1987. Final legal documents were signed on February 16, 1988. Shortly after Trinity Health Systems, Inc. acquired St. Mary's from SSM Healthcare, St. Mary's was closed as a general acute care hospital and became the site for the psychiatric and alcohol/chemical dependency services of Trinity Lutheran Hospital.

Trinity Lutheran Hospital is run by a governing board comprised of approximately 26 people, two of whom are previous board members from St. Mary's. The occupancy rate at Trinity Lutheran Hospital is now 63 percent, with an average daily census of 171.

WHAT WERE THE PROBLEMS AND WHY DID THEY MERGE?

The primary reason for the merger was the failing financial condition of St. Mary's, and the desire of SSM Healthcare to divest itself of that facility, which was draining the entire system. Trinity Lutheran Hospital wanted to increase its market share by acquiring the physicians and patients from St. Mary's; Trinity feared that a competitor might purchase the facility if it did not. According to respondents, if St. Mary's had not been acquired by Trinity Health Systems, Inc. or some other health care organization, SSM Healthcare would eventually have closed the hospital and sold the real estate.

Many of St. Mary's financial problems have been attributed to the changing demographics of the area. The migration of families out of the area had a particularly negative impact on family-practice-oriented St. Mary's. The aging population which remained in the area could not support the facility adequately, particularly the obstetrical and gynecological services. Trinity Lutheran Hospital, on the other hand, offered a higher level of acute care services and was not affected as much as St. Mary's by these demographic shifts. Both hospitals were experiencing declining census and were duplicating some services. St. Mary's also was losing physicians due to aging of the staff and some migration to the suburbs.

The entire Kansas City area was overbedded, according to respondents. Five blocks from Trinity Lutheran Hospital and St. Mary's Hospital was Truman Medical Center, the city's 271-bed community hospital. Within a 2 to 5-mile radius were St. Luke's Hospital, Menorah Medical Center, Research Medical Center, Baptist Medical Center, St. Joseph's Hospital, Bethany Medical Center, and the University of Kansas Hospital.

WAS THE MERGER CHALLENGED?

There were no obstacles to the merger, although a small group of Catholics who supported St. Mary's felt a certain sense of loss and elected to go to another Catholic hospital rather than use Trinity Lutheran Hospital. The majority of the St. Mary's patients and physicians did move to Trinity Lutheran Hospital. Efforts were made to absorb the non-medical staff into Trinity Lutheran Hospital; those employees who could not be accommodated at Trinity Lutheran Hospital were provided severance pay. No antitrust enforcement agency challenged the merger.

DID THE MERGER AFFECT THE AVAILABILITY OF HOSPITAL SERVICES?

The availability of hospital services was unaffected by the merger. All pre-merger services continued, with the exception of obstetrical services. Trinity Lutheran Hospital in Kansas City, Missouri elected not to offer obstetrical services after the merger with St. Mary's Hospital. Trinity Lutheran had not offered obstetrical services for at least a decade prior to the merger because of local demographic changes and the fact that hospitals nearby still offered obstetrical care.

The area surrounding Trinity Lutheran Hospital, "midtown," had changed from young, middle class families to a predominantly elderly population living mainly on Social Security benefits.

Statistics from the AHA on the number of births and bassinets in the hospitals serving the area of "midtown" indicate that births and bassinets at St. Mary's had steadily declined in the three years preceding the merger. The Medicare utilization rate at Trinity Lutheran Hospital increased by 160 percent from 1986 to 1989, clearly demonstrating an increase in the volume of elderly patients.

Trinity Lutheran Hospital and St. Mary's served the indigent before the merger and Trinity Lutheran Hospital continues to do so. There were no changes made in policies at Trinity Lutheran Hospital regarding charity care. The amount of uncompensated care provided by Trinity Lutheran Hospital doubled after the merger, and the hospital's Medicaid utilization increased by 472 percent from 1986 to 1989. These figures imply that Trinity's services were available to and used by the former patients of St. Mary's. Further, respondents believe that the merger improved the quality of care at Trinity Lutheran by increasing the volume and frequency of specialized procedures.

There is a perception that a "domino effect" was averted by the acquisition of St. Mary's. If it had closed outright, according to some respondents, the closure would have created a fear on the part of the physicians and the community that Trinity Lutheran Hospital was next. This could have caused a flight from Trinity Lutheran Hospital, creating a self-fulfilling prophecy.

In February of 1990, Trinity Lutheran Hospital entered into another merger, this time with Research Medical Center, a 100-bed general acute care hospital about 5 miles from Trinity Lutheran Hospital. The merger involves sharing administrative services and creating efficiencies by sharing personnel to accommodate the peaks and valleys of activity at each hospital. The arrangement prevents the loss of personnel who require full-time employment and saves the hospitals from paying expensive overtime rates.

*St. Francis Medical Center
Grand Island, NE*

*Grand Island Memorial Hospital
Grand Island, NE*

merged into

**ST. FRANCIS MEDICAL CENTER
GRAND ISLAND, NE**

WHAT WERE THE HOSPITALS LIKE BEFORE AND AFTER THE MERGER?

Prior to merger Grand Island, Nebraska, a community of about 40,000, had three hospitals: Veterans Administration Medical Center (162 beds); Grand Island Memorial Hospital (114 beds); and St. Francis Medical Center (131 beds). Grand Island Memorial Hospital and St. Francis Medical Center were located only 3 blocks apart. Both were general acute care facilities, offering approximately the same mix of services, and competing for referrals.

The administrations and boards of the two hospitals negotiated a merger. The Sisters of Charity Health Care System, the parent corporation of St. Francis Medical Center, offered to acquire Grand Island Memorial Hospital. Lutheran Hospitals and Homes Society of America, parent of Grand Island Memorial Hospital, accepted the offer in April of 1987. The merger agreement included a plan to close one of the two facilities as a general acute care hospital. Following a review and analysis by a consultant, the merged hospital board opted to close the Grand Island Memorial Hospital facility.

St. Francis Medical Center now has 139 acute care beds. The former Grand Island Memorial Hospital building is used for expanded outpatient services and for a new skilled nursing facility.

WHAT WERE THE PROBLEMS AND WHY DID THEY MERGE?

Admissions were declining at both hospitals. Occupancy rates were around 50 percent. Grand Island Memorial Hospital was losing money and incurring debts. Respondents said Grand Island Memorial Hospital would have inevitably closed. St. Francis Medical Center was faced with the threat of losing its Rural Referral Center designation if admissions continued to decline. Competition between the hospitals was financially draining and damaging the community's perception of both. Both administrations agreed that they were in a deteriorating situation.

WAS THE MERGER CHALLENGED?

No objections to the merger were raised. All staff at the Grand Island Memorial Hospital were offered jobs at the new hospital and counselors were available to help ease any stress caused by the changes. Prior to the merger most of the physicians had staff privileges at both facilities, and had already begun holding combined staff meetings. To further insure integration, three board members from Grand Island Memorial Hospital were added to the governing board of the new hospital. No antitrust enforcement agency challenged the merger.

DID THE MERGER AFFECT THE AVAILABILITY OF HOSPITAL SERVICES?

The availability of services has improved for the community. Respondents said the merger made it possible to add and expand services. The Grand Island Memorial Hospital facility provided needed space for services, without the capital expense of building new facilities. The building now houses outpatient services such as: alcohol and drug rehabilitation services; eating disorders treatment; lithotripsy; hemodialysis; radiation and chemotherapy treatment; and mammography. The building also houses a new skilled nursing facility, offices and classrooms. St. Francis Medical Center has added a cardiac catheterization laboratory and plans to add rehabilitation services.

Due to the new hospital's religious affiliations, elective tubal ligation services were deleted. These services are available at a hospital 20 miles away.

Respondents say the financial strength of the hospital allows more charity care to be offered. The hospital has recently begun to help build clinics in remote areas to increase access and to insure referrals for inpatient care. The hospital administration estimates that approximately 35 percent of admissions now come from outside the county.

*Staten Island Hospital
Staten Island, NY*

*Richmond Memorial Hospital
and Health Center
Staten Island, NY*

merged into

**STATEN ISLAND HOSPITAL
STATEN ISLAND, NY**

WHAT WERE THE HOSPITALS LIKE BEFORE AND AFTER THE MERGER?

Prior to the merger, Staten Island Hospital was a 470-bed teaching hospital on the north end of the island. It offered many sophisticated inpatient procedures and clinical services. Although the hospital was located in a middle-income area, many of the clinic patients were covered by Medicaid or not at all. Richmond Memorial Hospital was a 172-bed community hospital located on the south end of the island, 8 miles away. In addition to basic medical/surgical services, it offered outpatient psychiatric services and methadone treatment.

In 1987 the hospitals merged under a corporate umbrella, Community Health Systems of Staten Island. For the first two years of the merger nothing changed in the operation of the two facilities. In 1989 a new CEO encouraged further consolidation and a single Medicare provider number was requested and granted. The medical staffs were integrated by June 1990.

The hospital has recently been renamed Staten Island University Hospital. The former Staten Island Hospital site became University Hospital North, and the former Richmond Memorial Hospital site became University Hospital South. Basic medical and surgical services at both locations have remained the same, and new facilities and services have been created.

WHAT WERE THE PROBLEMS AND WHY DID THEY MERGE?

Richmond Memorial Hospital served a sparse population and the medical staff was dwindling. Occupancy rates were low compared to other hospitals in New York. There was a cash flow problem and malpractice insurance rates were increasing. Renovations completed in 1986 did not upgrade the operating rooms, which limited the new services it could offer. According to respondents, the hospital did not serve enough low-income patients to meet its Hill-Burton obligations because of its location.

Staten Island Hospital was a financially sound hospital due to strong investment returns. However, it was overcrowded and unable to meet patient demands. Because of strict controls on hospitals by the State of New York, the hospital was not permitted to expand. Some respondents feared that the overcrowding would force the hospital to reduce services, especially clinics which served primarily Medicaid and charity patients.

Richmond Memorial Hospital sought a merger to ease its financial problems. Most physicians at Richmond Memorial Hospital already had admitting privileges at Staten Island Hospital and the same union represented workers at both. After 18 months of planning and development, the

administrations and boards of the two hospitals agreed to become part of a holding company, the Community Health System of Staten Island. The merger was designed to better integrate services and improve service delivery; maximize resource utilization; eliminate duplication; produce economies of scale; and recruit staff.

WAS THE MERGER CHALLENGED?

No formal opposition was presented to the merger. The merger had been planned to minimize objections. Staten Island Hospital's former CEO became the CEO of the merged hospital, while Richmond Memorial Hospital's former board chairman became chairman of the new board. All board members were offered positions on the new hospital board or on the boards of subsidiaries of the new corporation. All staff were guaranteed job security and the medical staffs were given three years to consolidate.

The community raised no formal objections. A few people feared that the Richmond Memorial site would be closed as a hospital and that the increased drug treatment services at that location would bring addicts to their neighborhood. No antitrust enforcement agency challenged the merger.

DID THE MERGER AFFECT THE AVAILABILITY OF HOSPITAL SERVICES?

The availability of services has not been diminished by the merger. Respondents believe that availability has been improved by the addition of services. Several specialized services were consolidated and expanded in the space available at the former Richmond Memorial Hospital. These services included inpatient alcohol and drug treatment services, psychiatric inpatient services, geriatric services, and certain surgeries. Although this has increased the distance that a patient living in the north end of the island must travel by 8 miles, free van services are available and bus and rail lines are convenient for most.

Recently, a \$40 million ambulatory center was built adjacent to the former Staten Island Hospital. A new oncology center, a magnetic resonance imager, and an in-vitro fertilization clinic are housed in the ambulatory center.

*Allentown Hospital
Allentown, PA*

*Lehigh Valley Hospital Center
Allentown, PA*

merged into

**THE ALLENTOWN HOSPITAL-LEHIGH VALLEY HOSPITAL CENTER
ALLENTOWN, PA**

WHAT WERE THE HOSPITALS LIKE BEFORE AND AFTER THE MERGER?

Prior to the merger there were three general acute care hospitals in Allentown. The two largest of the three, Allentown Hospital and Sacred Heart Hospital, jointly built a tertiary care facility in the suburbs in 1974, called Allentown Sacred Heart Hospital Center. By 1975 the joint venture was in trouble, and several lawsuits ensued. By the end of the decade, Allentown was embroiled in what was referred to locally as “the hospital wars.” The medical community, local religious and political leaders, and the general public polarized over the conflict.

In 1980 a judicial ruling “demerged” Allentown Sacred Heart Hospital Center. That ruling required that Sacred Heart Hospital become an independent hospital again. Allentown Sacred Heart Health Center was renamed Lehigh Valley Hospital Center. Members of the Sacred Heart Hospital board were replaced by newly-appointed members from the community. A holding company, HealthEast, Inc. (“HealthEast”), was created to manage both Allentown Hospital and Lehigh Valley Hospital Center. HealthEast has its own board comprised of community representatives.

During the 1980s both hospitals continued to add beds. By 1987 Allentown Hospital had 284 beds and Lehigh Valley Hospital Center had 462. Except for emergency services, very few medical services were duplicated between the two.

HealthEast also grew as a system. In addition to the two general acute care hospitals, it operated a hospital in Lehigh, Pennsylvania, two nursing homes, two family care centers, an alcohol and drug treatment center, a hospice and home care services. The company also oversaw a trust fund which raised donations for the system and operated a for-profit subsidiary. Some ancillary services once provided by each hospital, such as lab services, were consolidated into one service.

In 1987 (with a legal effective date of January 1, 1988) Allentown Hospital and Lehigh Valley Hospital Center merged, creating The Allentown Hospital - Lehigh Valley Hospital Center. The merged hospital was comprised of two sites, operated under two licenses, and had two Medicare provider numbers. The two boards were combined into one and one administration ran both sites. The Allentown Hospital - Lehigh Valley Hospital Center operates 803 beds.

WHAT WERE THE PROBLEMS AND WHY DID THEY MERGE?

The administrations and the boards of both hospitals said that the merger was a “natural progression” for the system. The merger was intended to make the operation of the two hospitals more efficient. It reduced overhead costs by eliminating duplicative management positions.

The Allentown Hospital - Lehigh Valley Hospital Center is the largest hospital in Pennsylvania. Some board members and staff say it is now easier to recruit prominent administrators and specialists. The capital position of the combined hospitals has improved. The merger also allowed the sizable Pool Trust Fund, donated to the Lehigh Valley Hospital Center, to be used to fund projects at The Allentown Hospital.

WAS THE MERGER CHALLENGED?

There have been no organized objections to the merger. Most of the community was unaware that a merger had occurred. About 90 percent of the physicians at both sites had staff privileges at both hospitals before the merger and even before the merger the two medical staffs were holding combined meetings. No antitrust enforcement agency has challenged the merger.

DID THE MERGER AFFECT THE AVAILABILITY OF HOSPITAL SERVICES?

The merger had no affect on the availability of hospital services. For the patients at both sites nothing has changed. Occupancy rates have remained stable. The mix of services offered at each site has not changed. The Allentown Hospital, located in the western end of town, continues to provide the primary care, obstetrical and gynecological services, psychiatric services, pediatrics and clinics. The Lehigh Valley Hospital Center, in the suburbs west of town, is a secondary/tertiary care facility. It operates with state-of-the-art equipment and techniques, and has developed a regional market for certain specialties, such as open heart surgery.

The hospital has not merged again since 1987. However, in 1988 the Lehigh County Board of Assessment Appeals revoked the tax exempt status of The Allentown Hospital - Lehigh Valley Hospital Center. As a result of this revocation action, the Court of Common Pleas of Lehigh County, Pennsylvania ordered an accounting of the stewardship of the hospital. This audit was initiated because the loss of the hospital’s tax exempt status called into question its charitable nature. The audit culminated in an Adjudication and Decree, issued in July of 1990 by Judge Robert K. Young.

Judge Young stated in his Adjudication that, “There is nothing harmful in HealthEast wanting to do well with its Hospitals, but its main purpose must be to provide quality health care at an affordable price.” He went on to say, “The Trustees must remind the community that access to proper health care is not only a basic human right, but that the lack of care to any significant group of residents has a direct negative effect upon all of us.” “HealthEast,” he said, “has become too powerful and too controlling.”

The Judge charged the Board of Trustees with addressing the prevailing perception that HealthEast is misusing its power and with setting policies based upon health care needs of the citizens of the area rather than “primarily for the purpose of gathering or holding onto patients, or of enlarging the investment portfolio.” Finally, Judge Young required that the hospital be audited by the Court again within five years from the date of the Decree.

*Methodist Hospital of
Middle Tennessee
Winchester, TN*

*Emerald-Hodgson Hospital
Sewanee, TN*

merged into

**METHODIST HOSPITAL OF MIDDLE TENNESSEE
WINCHESTER, TN**

WHAT WERE THE HOSPITALS LIKE BEFORE AND AFTER THE MERGER?

Prior to the merger there were two general acute care hospitals in Franklin County, Tennessee. Methodist Hospital of Middle Tennessee in Winchester operated 103 beds, and, 13 miles away, Emerald-Hodgson Hospital in Sewanee operated 42 beds. Methodist Hospital of Middle Tennessee served primarily the residents of Franklin County (population 31,000), which was an economically-stable rural county in middle Tennessee supported mainly by agriculture and some light manufacturing.

Methodist Hospital of Middle Tennessee was owned and operated by Methodist Health Systems, Inc., a not-for-profit, multi-hospital corporation. Emerald-Hodgson Hospital was owned by the University of the South, but was managed and operated by a series of not-for-profit hospital management corporations, the last of which was Erlanger Health Systems, Inc. Emerald-Hodgson Hospital served primarily Grundy County, population 13,800, which is contiguous to Franklin County. Once a prosperous coal mining area, Grundy County was economically depressed and its residents were predominantly low income, elderly.

Before the merger, Methodist Hospital of Middle Tennessee's occupancy rate was 52 percent, with an average daily census of 54. Emerald-Hodgson Hospital had an occupancy rate of 23 percent, with an average daily census of 10. Both facilities served Medicare and Medicaid patients. The mix of services offered at both hospitals was virtually the same, including a computed tomographic (CT) scanner, obstetrical services, and a complete emergency department.

After the merger, which occurred on October 26, 1987, Emerald-Hodgson Hospital still belonged to the University of the South and was leased to and managed by Methodist Health Systems, Inc. The Methodist Hospital of Middle Tennessee facility in Winchester was thereafter regarded as the full-service general acute care facility, and Emerald-Hodgson Hospital its satellite. The merged hospitals are run by a board of directors which is comprised of lay people, medical staff, and administrative staff.

WHAT WERE THE PROBLEMS AND WHY DID THEY MERGE?

The primary reason for the merger was the imminent bankruptcy of the company which was leasing Emerald-Hodgson Hospital prior to the 1987 merger, Erlanger Health Systems, Inc. ("Erlanger"). As a result of Erlanger's serious financial problems, rumors were rampant throughout the area that Emerald-Hodgson Hospital was going to close. Some respondents felt that the quality of care at Emerald-Hodgson Hospital had declined. Emerald-Hodgson Hospital

was losing medical staff and money and had an extremely low census. The morale of the non-medical staff was low, and the community was losing confidence in the institution. The University of the South sought another health care organization to take over the management function. Methodist Health Systems, Inc. responded.

WAS THE MERGER CHALLENGED?

There was a great deal of anxiety on the part of the employees regarding the security of jobs and benefits. The community was quite skeptical that the merger could save Emerald-Hodgson Hospital from closing. However, no obstacles were presented to the merger. No antitrust enforcement agency challenged the merger.

DID THE MERGER AFFECT THE AVAILABILITY OF HOSPITAL SERVICES?

The availability of services actually improved, primarily for elderly, low income residents of Grundy County. Although certain services were deleted from the Emerald-Hodgson facility, it and the facility in Winchester are both more accessible to the residents of Grundy County via a free transportation system. A toll-free telephone line was installed in Grundy County for residents to request the van service.

The services which the Emerald-Hodgson facility lost are still available at the facility in Winchester. Those services include outpatient surgery, an intensive care unit, obstetrics (birthing room, labor room, delivery, recovery room), and a computed tomographic (CT) scanner. Patients at the Emerald-Hodgson site who need any of these services may be transported to the facility in Winchester by the free van service.

Methodist Hospital of Middle Tennessee added a myriad of outpatient and inpatient services and programs, and an outpatient and inpatient alcohol/chemical dependency unit and services. A helipad was built at the Emerald-Hodgson site for receiving emergency cases, and skilled nursing and long-term care were added.

AGENCY COMMENTS

The draft report entitled “The Effects of Hospital Mergers on Access to Care” was submitted for comment to the appropriate Operating Divisions within HHS and the Secretary’s Task Force on Hospital Merger. We received written comments on the draft report from the Assistant Secretary for Planning and Evaluation and verbal comments from members of the Secretary’s Task Force on Hospital Merger. Both remarked that the focus of the study is availability of services, not the broader and more complex issue of access to care. We agree. An analysis of the many issues relating to access to care is beyond the scope of this study. We, therefore, changed the name of the report to reflect more clearly its narrower focus.

ENDNOTES

1. Edward A. Grant, CPA and Edward J. Giniat, CPA. "Evaluating Mergers and Acquisitions with a Purchase Investigation." *Healthcare Financial Management*. April 1988.
2. For an overview of concerns in the hospital industry see Marybeth Burke. "Mixed Signals from Government Have Chilling Effect on Mergers." *Hospitals*. June 5, 1990. See also "HHS Neutral on Hospital Antitrust?" *Health Policy Week*. February 12, 1990 and Tinker Ready. "Court Axes Merger of Two Non-Profits." *HealthWeek*. March 6, 1989.
3. Merit C. Kimball. "Will HHS Advise Justice, FTC on Hospital Antitrust?" *HealthWeek*. February 26, 1990.