

What went wrong between Penn State and Geisinger, and what lessons should be learned?

Case Study of a Failed Merger of Hospital Systems

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ABSTRACT

The failed merger between Geisinger Health System and Hershey Medical Center is an instructive case study. The advantages of merging include: 1) support of financially threatened academic health centers, 2) access to greater capital, and 3) integration of managed care principles in the delivery system. Nevertheless, if the leadership of the new organization fails to deal effectively with the inevitable winners and losers, underestimates the role of cultural differences, does not have the management skills necessary to achieve cost savings and address the operational inefficiencies resulting from a larger clinical enterprise, does not anticipate the distrust of other local health care providers, and fails to anticipate the market forces that determine the success or failure of a managed health care system, mergers can fail. Lessons to be learned include: mergers involving health care systems with

competing programs need to plan aggressively and execute carefully their clinical consolidation; cultural differences and the impediments they cause can be easily underestimated; health system mergers do not automatically result in economies of scale; and not all stakeholders in the surrounding community necessarily will welcome a merger.

INTRODUCTION

In November 1999, the dissolution of the merger between Hershey Medical Center (HMC) and Geisinger Health System (Geisinger) was announced. Despite significant trends in the delivery and financing of health care, medical education, and research favoring the merger, it ultimately failed. What happened, and what can be learned from this situation?

Anatomy of a merger

One of Pennsylvania's largest health care systems was created in July 1997 when Penn State University leased the HMC to the newly formed Penn State Geisinger Health System. HMC was combined with Geisinger, yielding a single health care entity with 1,342 hospital beds, three hospitals, a drug- and alcohol-treatment facility, a managed care organization, 77 outpatient clinics, and more than 1,000 physicians scattered throughout 40 counties in northeastern and central Pennsylvania. Two of the hospitals, Geisinger Medical Center in Danville and HMC in Hershey, provided tertiary-care services within 70 miles of each other.

While the board of directors of the newly created system was split evenly between appointees from Penn State

University and the former Geisinger system, the chairman of the board was appointed by Geisinger and was granted the power of a tie-breaking vote. In addition, the membership of the executive committee of the board was weighted in favor of Geisinger — 4:3. The CEO of the new system, Stuart Heydt, MD, previously had served as Geisinger's CEO, while the dean of the Penn State College of Medicine, C. McCollister Evarts, MD, retained his title but also served as the new system's president and chief academic officer. Both had votes on the board of directors. While the new board of directors governed the clinical enterprise, Penn State University retained control of the College of Medicine, which remained attached to HMC at the Hershey campus.

Geisinger Health Plan, an HMO started by the Geisinger System in 1972, simultaneously was renamed the Penn State Geisinger Health Plan (PSGHP). It quickly was announced that HMC was a participating provider in PSGHP's network, effectively giving the HMO new access to south central Pennsylvania and a potential customer base of more than a million people.

Day to day, the Penn State Geisinger Health System operated as four geographic regions, modeled on the original Geisinger style of management. Before the merger, there were three geographic regions (east, central, and west), and HMC and its outpatient clinics were adopted operationally as a fourth, southern, region. Each region was led cooperatively by a pair of physician and administrator regional vice presidents, each of whom served with other senior ad-

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ministrators on a clinical practice committee that was chaired by the Penn State Geisinger CEO. The purpose of this committee was to approve new clinical programs, review existing program content, determine clinical priorities, and act as a forum for ongoing review of the clinical enterprise. There was also a system operations committee focusing on legal services, human resources, finance, and facilities management.

The right step?

Tertiary care and academic health centers were threatened. At the time of the merger, HMC and Geisinger were both financially healthy, yet leaders of both institutions endorsed predictions that local hospitals and physician groups would aggregate into large health care systems. They surmised that in addition to dominating local markets, larger systems would create economies of scale through the efficient provision of services throughout the care continuum.

Newspapers reported at the time that the new Penn State Geisinger Health System was expected to broaden medical services and expand access to treatment while concurrently reducing costs by \$105 million over the course of three years. Greater leverage in negotiating prices combined with lower costs were intended to ensure that HMC and Geisinger would survive in a marketplace increasingly penetrated by for-profit providers and managed care insurance plans.

According to Heydt, the Penn State Geisinger CEO, the Penn State University leadership also had little confidence that it would be able to lead HMC through an increasingly tumultuous health care market and "wanted to get out of the health care business." Penn State welcomed Geisinger's national reputation for health care management as a solution to HMC's increasing vulnerability.

Geisinger and Hershey no longer

had to compete. Geisinger officials were quoted in local news reports as stating that the two health care groups would generate significant savings by not competing with each other and by sharing resources.

HMC and the medical school needed access to greater revenue and more capital. During the late 1980s, HMC undertook significant construction while also supporting the considerable costs of postgraduate and medical education with revenue from clinical operations. Administrators there surmised that the capital markets would find the broader financial base of the newly merged system better able to support the future servicing of debt. In addition, an academic support formula was created, based on a percentage of revenue in excess of expenses, to tap into the more than a billion dollars in projected revenue and thus guarantee the financial health of the medical school and postgraduate education programs for the foreseeable future.

Geisinger wanted the luster of an affiliation with an academic health center. Geisinger had a longstanding if smaller commitment to research and education in the form of its graduate education programs. Geisinger's Weis Center for Research was incorporated into the medical school, and it was expected that the system's medical and postgraduate educational programs would become fully integrated.

Penn State's health insurance and education costs were considerable.

At the time of the merger, Penn State spent approximately \$75 million per year on health care benefits for its more than 16,000 employees who were not students. Large numbers of Penn State University and HMC employees signed up with PSGHP within a matter of months, and consideration was given to ultimately making PSGHP the exclusive employee-benefit option at both institutions. In addition, given that Penn State traditionally offered tuition dis-

counts to employees and families, the removal of HMC employees from Penn State's books also was expected to benefit the university's bottom line.

HMC regarded Geisinger Health Plan as an attractive asset. Though HMC had little reason to welcome any HMO's contracting style and utilization management, Geisinger Health Plan was a not-for-profit revenue center owned by a health system and led by physicians. It was expected that the HMO would grow considerably, and that the expansion of PSGHP into the areas surrounding HMC would not only achieve additional premium revenue for the bottom line, but would also fuel patient referrals to Hershey.

Why did the merger fail?

Consolidation and cutting costs failed to deal effectively with the inevitable winners and losers. The process of consolidation generated few problems in nonclinical departments (e.g., finance, marketing, and public relations); it stalled, however, when clinical departments at each of the two tertiary-care hospitals began to tackle leadership, ownership of tertiary or highly profitable clinical services (e.g., bone marrow transplant, invasive cardiology services, tertiary-level children's hospital care, high-risk obstetrics, and orthopedics), and merging of postgraduate educational programs (i.e., how would residents split their time between two medical centers?).

Whenever a disagreement developed, two camps — based on historical affiliations with either Geisinger or HMC — quickly emerged. The CEO, chief academic officer, and other system leaders then found themselves being lobbied by opposing constituencies. Because completing the merger also preoccupied the system's leaders, unresolved disagreements and ongoing debate enabled duplicative tertiary-care services to linger. Attempts to mediate

clinical program consolidation from the bottom up deteriorated into competitive advocacy. Overall system versus local work-unit conflicts of interest played out in meetings, memos, and appeals to higher levels of authority, including the board of directors and — if there were implications for either the academic mission or the medical school — the president of Penn State University.

Lacking consensus, the two tertiary-care medical centers in Danville and Hershey continued to offer separate and competing services. This dynamic was felt acutely by middle managers, many of whom responded with hardened loyalty to their immediate superiors. Long after the merger failed, there is still no shortage of unflattering anecdotes about delay, gaming, passive resistance, demeaning colleagues, bullying opponents, and failing to address conflicts of interest in a setting that was supposed to be dedicated to healing and service.

Theoretical cost savings never occurred and did not translate meaningfully into lower rates for health care purchasers or a better bottom line for the system. It was assumed that economies of scale would occur as a result of the merger. Health care delivery throughout the system's service area remained a highly localized enterprise, however, involving individualized encounters between one practitioner and one patient in the clinic, catheterization lab, operating room, or delivery suite.

As the system promoted a one-size-fits-all approach to disparate settings across its wide service area, operational inefficiencies persisted and fixed costs remained. Due to the often contentious competition for resources among various departments and regions in the two camps noted above, there was minimal incentive to reduce costs. The continuously expanding appetite for revenue and capital to support patient care, education, and research cemented Geisinger's and HMC's reputations

as expensive tertiary-care facilities. Lacking any visible fulfillment of the savings promised at the time of the merger, which was to be accomplished with reduced service charges, the system failed to convince the local marketplace that its high cost structure was good for health care. At the same time, the Pennsylvania attorney general responded to local sentiment that a monopoly in tertiary care in central Pennsylvania combined with an exclusive relationship with a single HMO was unlikely to result in lower prices for consumers, and withheld final approval of the merger.

The cultures of the two merged systems were extremely different. While Graham Spanier, the president of Penn State had been quoted in news reports as saying, "The similarity of cultures between Penn State and Geisinger is another strength in the relationship we are proposing," his optimism quickly dissipated. HMC's style of collective governance by cooperating with independent and strong academic departments clashed with Geisinger's style of managing full time, salaried physicians in a multispecialty group practice.

As Geisinger-pedigreed administrators descended on HMC, academic physicians already struggling to secure grant support for research and to find time for teaching were confronted by management expectations that their clinical practices must be profitably self-supporting. Consternation turned to anger when HMC physicians were asked to examine their billing practices, outpatient clinic throughput, operating-room times, support-staffing procedures, market-driven measures of physician compensation, indirect costs, the expense of medical education, and unfunded research activities.

In south central Pennsylvania, there was a lack of community-provider support. There was also practitioner distrust, particularly with respect to Geisinger and Geisinger's HMO. Physicians in

northeastern and central Pennsylvania who were not associated with PSGHP suddenly were confronted with the presence of a large and powerful system that was intended to leverage services and contracts favorable to its own interests. These physicians viewed this as an alarming expansion of both Geisinger and HMC into new areas of the state, with serious implications for local independent practices and hospitals. They quickly assumed that the real purpose of the merger was to secure profits and restrict choice, and resisted any expectation to refer patients to PSGHP or to participate in its HMO.

Previously existing fragile relationships between HMC and some local community hospitals — which included the joint purchasing of supplies — were dissolved quickly, and other hospitals' animosity toward HMC and Geisinger increased. The distrust also resonated among the nonphysician employees of HMC, complicating the contentious negotiations between the union representing the nurses (who had watched their tuition benefit evaporate) and the newly constituted administration of the HMC in the fall of 1997.

PSGHP could not deliver. Already suspicious of HMC's hunger for high-margin procedures and high occupancy rates, hospitals in surrounding locales such as York, Lancaster, Harrisburg, and Lebanon viewed PSGHP as an HMO with one purpose: to funnel patients away from them and to Hershey. Accordingly, they saw little advantage to participating in PSGHP's network and either delayed negotiating for as long as possible or offered unacceptable contracting terms. Despite the predictions about the statewide aggregation of health care entities, area community hospitals remained fiercely independent and continued to enjoy local physician and patient loyalty. Since PSGHP failed to develop an adequate area-delivery network, most employer-purchasers of

health insurance in the areas surrounding HMC effectively sided with their area's community hospitals and refused to offer PSGHP to their employees. Accordingly, projected HMO membership, premium revenues, and patient referrals fell far short of expectations.

The final straw

By the fall of 1999, Penn State Geisinger Health System chairs had been appointed for each of the major clinical disciplines, but clinical departments at HMC continued to have significant autonomy. One southern regional vice president was quoted as having said that he viewed his role as being akin to running a "health care mall" for independent merchants, while each original Geisinger region was tightly administered by the regional vice presidents.

At the same time, academic chairs were appointed to oversee the various teaching and research programs. As a result, none of the senior leaders in place prior to the merger experienced any decrease in their level of responsibility, while at the same time additional layers of administration were added. Given the complex chain of command and the daunting challenge of managing a large health care system, attempts by clinical leaders to promote integration or consolidation of programs and reduce costs languished. Frustration mounted, and disaffection with the merger began to be shared at the highest levels. Moreover, the board of directors became polarized.

Below the senior level of management, the Penn State Geisinger Health System functionally comprised two affiliated yet distinct groups, identified as either Geisinger or HMC. Physicians from either side were familiar with each other but failed to systematically study or embrace each other's practice efficiencies, management styles, or patient-care patterns. Except for a different sign outside, individual providers and

support personnel in the clinics and hospitals saw no change in day-to-day operations, and business continued as usual. At the same time, projected revenue from clinical operations and cost efficiencies failed to materialize, and increasingly negative actual-vs.-projected budget gaps began to develop in all four regions.

In the year following the merger, each region failed to achieve targeted budget projections, and the deficit reached \$30 million. As a result, during the second year of the merger, clinical program consolidation and cost management received heightened urgency, and acrimony increased.

The attempt to consolidate the Geisinger and Hershey microbiology laboratories was the final straw. Vans already were transporting laboratory specimens throughout each of the four regions from the outpatient clinics to each of the hospitals, and consolidating the two laboratories would have meant having the vans drive in one direction with no impact on clinical quality. Given that having one microbiology laboratory would have reduced overhead as well as the number of employees, a significant savings opportunity existed for the cost-per-test in an important revenue center.

Because administrative leaders at both medical centers did not value microbiology to the same degree as highly visible tertiary-care services such as open-heart surgery, the business plan for microbiology consolidation slowly advanced intact through the multiple layers of administration. Additionally, because Geisinger Medical Center appeared to have the most attractive cost structure, a major academic health center with an on-site medical school was about to go without an on-site microbiology laboratory.

When stakeholder physicians in microbiology at HMC learned of the plan, they publicly expressed grave reservations about the consolidation. The stakeholders included members

of the pathology department as well as the infectious disease section of the department of medicine. The argument quickly turned away from the already-settled issues of savings, layoffs, or overhead, and focused on the educational implications for the Hershey Pathology Residency and Infectious Disease Fellowship Programs, as well as the teaching of medical students. Offers to develop information technology solutions, distance learning, or even transport or living arrangements for on-site training at Geisinger Medical Center failed to take root, and rumors began to circulate that the residents and fellows were going to refuse to travel to the Geisinger campus.

The chief academic officer (who still served as dean of the medical school) wavered in his support of the consolidation plan, and the stakeholder physicians appealed to the president of Penn State University. When the president of Penn State and the Penn State Geisinger CEO failed to agree on the plan for consolidation of microbiology, consensus to undo the merger gained momentum. Dissolution of Penn State Geisinger was announced in November 1999.

Lessons to be learned

Superior leadership and management are necessary for mergers involving health systems with previously competing and tertiary-care programs. Other writers on the topic of mergers have observed that if the merger is based on cutting costs, the failure to quickly and effectively identify the winners and losers in program consolidation will give champions for duplicative programs time to promote business as usual. Moreover, the longer the delay, the harder and more dysfunctional the process becomes (Blecher 1998, Weil 2000).

Executing a successful merger involving previously separate and competing health care entities necessitates not only strong leadership, but also committed and nimble manage-

ment. If either of these attributes are lacking, success is threatened; if both are missing, it is doomed.

Cultural differences and the impediments they cause can be underestimated easily. Any organization possesses unique and immeasurable history, informal yet important relational networks, management styles, local opinion leaders, and institutional pride that can be easily underestimated in business plans but may act as powerful determinants of the success or failure of any merger (Baskin 2000; Pelligrini 2001).

In this instance, lingering differences in culture — independent academics committed to education and research on one side and full-time practicing clinicians deferring to centralized leadership on the other — effectively resulted in the inefficient persistence of two separate clinical organizations. These persisted in a single system, ironically named Penn State Geisinger. A corollary lesson may be that senior leaders caught up in the heady enthusiasm of a potential merger may be less able to objectively assess the suitability of their respective organizations' cultures.

Health system mergers do not automatically result in economies of scale. Greater organizational complexity superimposed on the same workforce and overhead will lead to expanded management challenges. At the patient level, health care remains a highly individual process, and simply aggregating it into a single organization does not lead to heightened efficiency. Further, greater organizational complexity combined with business-as-usual patient care does not yield greater revenue nor will it lower cost and risks. It may, in fact, lead to even greater financial stressors.

Not all stakeholders in the surrounding community will necessarily welcome a merger. While health system administrators may assume that anything that further enables their organization's missions of pa-

tient care, education, or research is laudable, local health care and government stakeholders are more likely to discern that health systems mergers have more to do with reducing competition, increasing market share, and enhancing negotiating power.

Despite predictions of their certain demise, many local hospitals and physician practices have remained quite independent (Bellandi 1995). Accordingly, depending on the marketplace and the number and types of leverage options, they can undercut the success of the merger by, for example, foregoing any previously existing collaborative agreements, altering referral patterns, and not cooperating with health insurance arrangements. The result may be community distrust, polarization of local health care providers, and increased regulatory scrutiny.

CONCLUSION

Merging two completely different health systems would be difficult under any circumstances. In the case of Penn State Geisinger, it was assumed that underlying market forces would favor a larger system comprising a large clinic, three hospitals, and an HMO with service-area dominance, greater revenue, lower costs, more capital, and increased patient referrals. Not only were the goals of this systems merger not attained, but also distinct cultural differences between the systems and a lack of buy-in from local health care providers created additional challenges.

Leadership failed to convince internal stakeholders of the merits of the merger while management continued with business as usual, allowing duplicative programs to linger. Even the ownership of an HMO could not overcome the local health care providers' reaction to the threat to their market share. Furthermore, "education and research" had little value outside the newly formed system.

As the nation's health care system continues to evolve, it remains to be

seen if large dominant health care systems will emerge. On the basis of what occurred with Penn State Geisinger, health care leaders may wish to review the lessons that have emerged: Bigger does not mean better, current leadership may not be up to the task of overcoming cultural differences, usual management may not be up to achieving higher efficiencies, and resistance among internal and external stakeholders can coalesce quickly.

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