Hospital Systems Today—Valuable Integration or Is It Time to Cut the Cord?

By J. Mark Waxman and Janice A. Anderson, Foley & Lardner LLP

INTRODUCTION

Since the early 90s, there has been a well-documented trend by acute care hospitals toward participation in healthcare systems.[1] Indeed, even today, multi-hospital systems (Systems) continue to be created.[2] Currently, over 55% of hospitals exist in a System of one kind or another, and System arrangements generally appear to provide value for the members of the System individually, and for the System as a whole.[3]

Over the past two years, however, there have been signs that the effectiveness of Systems in delivering real value for all of their members may be questioned. This can occur, for example, when Systems are forced to favor one member over another in capital allocation decisions, or when hard decisions must be made with respect to marginally performing entities, often those located in inner cities. As a result, we have seen a number of hospitals either leaving one System for another, such as Mercy Hospital's move from Catholic Healthcare East to the University of Pittsburgh System, or the departure of St. Mary's Hospital in Louisville from Catholic Health Initiatives to join the Jewish Hospital & St. Mary's Inc. Healthcare System. The recently announced negotiation to separate Albert Einstein Health Network from Jefferson Health System, which it joined a decade ago, may return an entity and its affiliates to freestanding status. And, as a reminder that Systems that cannot negotiate resolution of System issues peacefully may face challenging public disputes, there is the ongoing litigation between The Christ Hospital and the Health Alliance of Cincinnati to effect its separation.[4]

This is not to suggest that the only solution to System challenges is either divestiture or dissolution. While some System models may be evolving toward closer integration to achieve the values that "systemness"[5] can bring, a number of Systems (e.g. the CareGroup Healthcare System in Boston, MA) have evolved into a "confederate model" that seeks to maximize the purely financial benefits of System financing, but preserve the independence of System affiliates to operate within their markets, pursuing their own clinical initiatives.

This article considers the structure of Systems today from the perspective of whether they continue to have value. Then, drawing upon the example of the Health Alliance of Cincinnati noted above, this article addresses situations where boards must assess the value of "systemness" or integration to determine whether it may indeed be outweighed by the duties a System affiliate has to its own constituencies.

THE GOALS UNDERLYING SYSTEMS

System creation, and the push to integrate hospitals into multi-hospital nonprofit Systems, was the product of a number of opportunities and market demands. While no one reason applies to every situation, the key factors that drove System creation in the early 90s were:

1. The potential to create better access to capital and reduce the cost of borrowing through a large and diversified credit pool;
2. Greater access to a pool of capital that can be spread across a System of affiliated hospitals;

3. A desire to achieve leverage in managed care contracting;
4. Economies of scale in administrative services, purchasing, and revenue cycle activities that can result in lower operating costs and greater efficiency;
5. Competitive advantages in markets where System hospitals can compete better with unaligned hospitals;
6. The potential to enhance clinical management and quality initiatives across patient populations;
7. The potential within markets to integrate care delivery and create centers of excellence; and
8. The ability to retain aggregate patient flows and revenues within System boundaries.

THE BALANCE OF MISSION

In the typical System, all members usually are organized as separate charitable nonprofit corporations. The members typically have deep historic roots in their local communities, and their missions and strategies traditionally have been purely local in nature. As a result, their assets (leaving aside restricted funds and endowments) are typically seen as pledged to the benefit of locally related charitable activities. A local entity that changes the use of its existing assets to support System goals must ensure that the change is consistent with legal requirements that apply to its charitable mission, and any attendant state-imposed charitable restrictions.[6] Thus, an important challenge for all Systems is to ensure that "systemness" does not thwart the charitable mission that grounded the participating System members in the first instance.

In contrast to the specific and long-standing missions of most System members, the mission and goals of the System are generally new and necessarily must be stated broadly, so as to encompass the varied missions of its individual members, and potentially a broader community. The Mission Statement for the System can be found in the documents that create the System, and must then be carried forward to the governing documents (such as the Charter, Articles, and Bylaws) of the System parent, along with all System members.

Over the past two years . . . there have been signs that the effectiveness of Systems in delivering real value for all of their members may be questioned.

Unfortunately, in many Systems, the statement of mission and goals rarely highlight any real difference between the mission of the individual affiliates and the System as a whole. It can become a challenge, therefore, to discern where the boundaries and balance of the mission for the System participants truly lies by looking at the stated mission and goals alone. This is particularly true when there is conflict between the System parent and one of its members. Questions of mission and goals may become acute when Systems are confronted with issues of capital allocation, or in the event of intra-System clinical competition.

ALLOCATION OF DECISION-MAKING AUTHORITY

Aside from ensuring that the state protected charitable mission for the System members is safeguarded within a System context, the practical challenge to most Systems centers on the thorny issue of where decision-making authority within the System resides. Will the System's goals be best achieved if decision-making is centered at the System parent level? Or are some decisions better made at the local level due to the unique nuances of the local market and its supportive constituency? The resolution of this authority issue is complicated, and many Systems grapple with it long after their formation.

Decision-making authority is typically grouped into categories—which usually are articulated in the corporate documents through an enumeration of "reserved powers" held by the System parent. It is often embodied in a "governance" or "authority matrix" delineating hierarchical decision-making authority at the various decision points across the System. The typical authority matrix addresses the division of authority and responsibility between System affiliates and the System parent. As one model has expressed it, the authority matrix advises when the affiliate or the parent must consult, recommend, notify, or approve any particular action or event. The key areas covered in the typical authority hierarchy include the following:

1. Selection of membership on the System parent Board and on Boards of the System affiliate (typically focused on the first tier affiliates);
2. Determination of mission, strategic plan, and corporate affiliations of the System parent and its affiliates;
3. Approval of operating and capital budgets and targets;
4. Creation or addition of new affiliates/joint ventures or long term contractual alignments;
5. Financing activities;
6. Major or material (as opposed to short term) capital expenditures;

7. Capital allocation;
8. Selection and removal of the Chief Executive Officer of the System parent and the affiliates;
9. Material asset sales or divestitures; and
10. Closure or significant expansion of clinical service lines.

The range of ways Systems balance decision-making authority is as varied as there are Systems. Some Systems are "system-centric"—with a large share of the decisions to be resolved by, or only with the approval of, the System parent—while other Systems have limited centralization, for example where the System parent's authority is limited to issues related to centralized debt management. In all cases, however, the oversight authority granted to the System parent is created by written documents; either by a contract (e.g. through a Joint Operating Agreement), or by specific "reserved power" provisions in interrelated bylaws of the System parent and its affiliates. Although resolution of the "central vs. local" decision-making conundrum may vary widely, what remains in common for virtually every System is the tension between the need for central or local control.

The tension that occurs as a result of the allocation of decision-making authority is best illustrated when Systems face questions about the allocation or reallocation of assets between System members. For example, assume System A has five hospitals scattered over five separate markets. Assume further than one of the System hospitals is located in a favorable market and is earning banner operating margins, while another System hospital, located in a more challenging market, is losing money. From the System perspective, the imbalance could easily be rectified by simply allocating operating income from the "good" hospital to its under-performing affiliate. In a strong centralized decision-making model, implemented through the System governance documents, the System parent could make this transfer, presumably to the benefit of the System as a whole. However, is this really to the benefit of the well-performing entity and, more importantly, to the community it serves? The well-performing hospital may consider this asset allocation to undermine its ability to meet its local mission, by diverting its assets to its poorer affiliate. This conflict created when decisions affect the "good of the whole" versus the "good of the component," and the ability of the System to peacefully resolve them, can test the very fabric of "systemness," creating fertile ground for claims to disaffiliate.

Unfortunately, in many Systems, the statement of mission and goals rarely highlight any real difference between the mission of the individual affiliates and the System as a whole.

SYSTEM UNWIND PROVISIONS

As some systems have come together, particularly when the "glue" is contractual rather than through a corporate membership model, different approaches to defining when to terminate the arrangement have been used. In some cases, withdrawal is not allowed so long as certain measures of success are achieved. In others, withdrawal is permitted at the election of a System participant. One straightforward approach is a defined withdrawal agreement that allows withdrawal by any participant after a fixed time (e.g. 10-20 years) has elapsed, with a process to unwind the arrangement including reallocation or unwinding of capital and debt. If the parties believe the arrangement remains mutually beneficial, they can agree to "re-up" in the arrangement. If not, there can be an orderly withdrawal.

A second approach is one that allows for affiliate withdrawal if certain metrics applied to the System as a whole are met, at the option of either the parent or the affiliate. These metrics typically may include:

- A demonstration that no financing or contractual defaults would occur from the withdrawal;
- Financing metrics for the System that remain at the same levels post-departure (e.g. days of cash on hand, capitalization ratio); and
- After withdrawal, the withdrawing member can obtain comparable financing as it could within the System.

The foregoing metrics generally are seen as a "do no harm" approach to withdrawal.

A third approach avoids defined departure "trigger" metrics for withdrawal but allows the parties to discuss disaffiliation at given intervals. Under this approach, there is an evaluation of whether the System and its affiliates are meeting the goals of their stra-

tegic and capital plans that usually have been developed as an initial step following integration.

Another approach requires the System to develop specific goals, both at the System and affiliate level that, if not attained, may trigger the right of any member of the System to withdraw. Such goals might include whether the System and each of its affiliates have achieved an agreed-upon operating margin within a defined time period, or whether an agreed-upon amount of new capital has been generated for System affiliates over an agreed time period.

The key to each of these approaches is, of course, an ability to reach an agreement initially among System members on the appropriate benchmarks to success. That agreement, which may be either in the form of defined metrics or a defined process to identify those metrics, is best reached through negotiation prior to System creation. This allows for clarity and understanding by the respective parties of their shared goals, and how they have agreed to achieve them, and should be carefully documented in the organizational documents.

TESTING THE SYSTEM—THE CINCINNATI HEALTH ALLIANCE EXPERIENCE

The Health Alliance of Greater Cincinnati (Alliance) was created in 1995. Using a Joint Operating Agreement (JOA), The Christ Hospital, (TCH), St. Luke Hospital, the University of Cincinnati College of Medicine, Jewish Health System, and Fort Hamilton Hospital (known collectively as Participating Entities), came together by contract to create a "virtual merger" of the Participating Entities. Unfortunately, a dispute erupted where, in the view of the court in which the litigation is pending, there was "a clash of fundamental perceptions over what kind of structure" had been created.[7]

The JOA (as subsequently amended in 2001) articulated a structure for the Alliance that included the following elements:

1. Strategic Goals that included the goal of enhancing the healthcare needs of the communities served by the Participating Entities through an integrated delivery system, and through the development of shared risk arrangements;
2. The formation of a Joint Operating Company (JOC)—i.e. the Alliance parent entity—which was to have responsibility for the "overall management and supervision" of the Alliance, with the authority to enter into contracts on behalf of the Participating Entities (subject to reserved powers), as well as to develop, administer, conduct, and carry out marketing and business development, consolidate management and, more generally, "manage and oversee daily operations of the Alliance;"
3. The property, plant, and equipment of the Participating Entities would continue to reside in each entity, subject to the power of the JOC to "in its discretion . . . cause a Participating Entity to relocate or transfer ownership of its [property, plant and equipment] to the JOC or another Participating Entity;"
4. The Participating Entities themselves were to continue to exercise "ultimate responsibility for fulfilling their respective charitable missions and obligations;"
5. The JOC itself was to operate consistent with the charitable missions of the Participating Entities;
6. It was an event of default for the JOC to fail to comply with the JOA provisions; and
7. An uncured default would permit a Participating Entity to terminate its participation and withdraw from the Alliance.

At the Alliance's inception, all Participating Entities saw mutual advantage. Over time, however, those views changed dramatically. By mid-2006, the TCH Board concluded that, although TCH generated 40% of Alliance revenues, it was being under funded by the JOC, while the Alliance was devoting significant capital to build a new hospital. Where the JOC questioned TCH's viability in its current location and even envisioned an absorption of TCH by another Alliance member (the University Hospitals), the TCH Board, after its own investigation of the facts, concluded that TCH not only could be successful with or without its membership in the Alliance, but, because of the Alliance's failure to realize the value of its clinical goals, THC could well be stronger in the pursuit of its mission if it became independent. Ultimately, TCH decided to withdraw from the Alliance, because continued participation was no longer in the best interests of TCH's charitable mission as determined by the TCH Board, which had reserved to it the "ultimate" authority over decisions respecting THC's mission.

The TCH termination notice was followed shortly thereafter by a similar notice of termination from St. Luke's Hospitals. Like TCH's Board, St. Luke's Board acted as the result of a number of issues, some past and some current, including a claimed mishandling by the JOC of a major source of patient referrals, JOC efforts to obligate St. Luke's to joint and

several financing obligations over its objections, and a refusal by the JOC to explore a voluntary withdrawal despite a showing that the economics of the withdrawal would benefit the Alliance.

Litigation between the parties commenced in March 2006, when the Alliance sued TCH to obtain a declaratory ruling to prevent its withdrawal. Notwithstanding court rulings in favor of TCH and St. Luke's, the litigation continues today and has drawn other parties, such as the Ohio Attorney General, into the fray.

To resolve the issues raised by the litigation, the court has focused on two key elements—(1) to what did the parties actually agree, and what duties were created as a result of their agreement; and (2) was the subsequent decision-making of the parties consistent with their agreed-upon duties and their inherent obligations. Thus, the analysis began with the JOA and other organizational documents, and then progressed to analyze the parties' actions in light of their agreed-upon obligations and the general common law legal principles governing decision-making by those involved in such structures.

Although on its face the JOA provided a great deal of operational authority in the JOC, it also provided that the power of the Participating Entities' Boards to exercise "ultimate" responsibility was unabridged. Because the JOA articulated that the JOC was to "operate the Alliance consistent with the charitable missions" of the Participating Entities, all of the relevant JOC decisions were to be measured with that goal in mind. As the court noted, although some may have visualized a "virtual merger" at inception, in fact, no "virtual merger" existed at all. Instead, the Participating Entity retained its right to determine its own separate mission, and there was no agreement (or, as a result, no requirement) that a single overriding or even system-consistent charitable mission was to be achieved.[8]

The resolution of this authority issue is complicated, and many Systems grapple with it long after their formation.

The court, however, looked beyond the JOA's specific provisions to find a higher or fiduciary duty in the JOC to the Participating Entities by virtue of its "special relationship" with them. Because, subject to certain reserved powers, the JOC was charged with the obligation to manage the affairs of the Participating Entities, collect and allocate their revenues, and employ their operational staffs, the JOC was duty-bound to act, not for itself or for the Alliance as a whole, but as a fiduciary to the Participating Entities individually. The court found this duty was breached, providing a basis for the Participating Entities to terminate the arrangement.

While the Alliance JOA structure may be seen as unique among Systems, the lessons of the litigation are many. First, the JOA terms were inconsistent and left gaps in defining governance obligations. On the one hand, the JOC was obligated to manage (with important reserved powers) the affairs of the Participating Entities, and to do so with the support of their revenue streams and with control over financing and access to capital. On the other hand, the unique mission of each Participating Entity was preserved, and the obligation to achieve that mission was left to the ultimate control of the Boards of the applicable Participating Entity. The lesson learned is deceptively straightforward: there must be congruity between power, authority, responsibility and mission at the System parent level.

In addition, although Participating Entity consent was required by the JOA to impose new joint and several debt obligations on the Participating Entities, the JOC had sought to impose those obligations without consent. The JOC also had taken a series of strategic actions without an agreed-upon strategic plan (which was required by the JOA) and these strategies impacted directly the mission driven desires of two of the five Participating Entities. In short, the facts showed that the JOC had acted inconsistent with terms articulated in the JOA, and in violation of its duties (deemed fiduciary duties by the court) to the Participating Entities, allowing TCH and St. Luke's to invoke their right to withdraw. This result also could have been easily foreseen. Operation without a clear framework in this kind of environment can result in more than just anxiety and bad feelings.

IMPLICATIONS FOR SYSTEMS AND THEIR BOARDS

How did the Cincinnati situation happen, and how could it have been avoided? The fundamental flaw in the Alliance structure originated from a lack of a clearly defined, agreed-upon, common mission and vision for the Alliance, approved and adopted by the Boards of all of the Participating Entities and articulated in a strategic plan approved by all of the Alliance Boards. Common mission/vision and strategic

plan are essential at the outset to establish "systemness" and should be embraced by all participants in the System. The participants should all conclude that the System mission/vision and plan bring them sufficient value to be worthwhile to meet both short and longer terms goals.

In addition, the Alliance failed to precisely identify an authority matrix to make clear the relative decision-making authority of the JOC vis-à-vis the Participating Entities. The authority matrix must implement the agreed-upon balance of governance responsibilities, cascaded to management, that is sought by the participants from the System. For example, if the only value to the System participants is financial, then the authority matrix (including all relevant corporate documents) should allocate decision-making authority to the System parent around that element, and control in other areas, such as clinical or operational decisions, should remain at the local level. If, on the other hand, the value of the "systemness" extends beyond financial issues to competitive and clinical activities, then the governance and management responsibilities identified in the authority matrix should reflect that as well.

Finally, the JOC seemingly failed to focus properly on its duties to the Participating Entities individually, and, instead, focused narrowly on what it perceived to be best for the System as a whole. Given that the individual Participating Entities remained committed to use their charitable assets to fulfill charitable purposes of the communities they served, a narrow focus solely on what is in the best interest of the System constituted a fundamental breach of the JOC's fiduciary obligation to the Participating Entities, paving the way for the Alliance's disintegration (and some very acrimonious litigation). By ascribing a fiduciary duty to the JOC in favor of the Participating Entities, the balance between the needs, desires, and goals of the Alliance as a whole vis-à-vis the Participating Entities was decided. The JOC's duty to support the Participating Entities would trump the System in every case.

THE VALUE OF SYSTEMS: TIME FOR AN EVALUATION

In 1996, James Orlihoff and Mary Totten described the characteristics of an integrated delivery system.[9] The elements included:

- Integration of care delivery and financing.
- Integration of physicians with the organization.
- Provision of an accessible continuum of care.
- Provision of high-quality, cost-effective care resulting from the integration of services and clinicians.
- A new form of integrated, systems-oriented governance.

Now, a decade later, the success of this model in truly achieving these characteristics and realizing value is being tested. On the one hand, there appears to be consensus that scale itself offers substantial benefits; if, for no other reason, it allows better access to capital.[10] These benefits can be realized, however, provided there is an adequate capital base to manage from at the outset, an agreement on common goals and strategy, and an overall objective to maintain and grow each of the System's participants, if only from a financial perspective.

The test arises, however, when the conditions change over time—the money to meet capital needs declines requiring difficult choices as to where to allocate dwindling funds, profitability across the system declines, or the markets change reducing returns on capital investment, or clinical integration has simply posed too big of a challenge. The participants in Systems seeking to address these circumstances will need to hearken back to the agreed-upon goals that brought them together initially and evaluate whether those goals remain. If they do, then System can honestly determine whether the goals, or at least some of them, still can be achieved and whether "systemness" continues to deliver value for the System, both individually and collectively. This requires high-level, objective review and evaluation, and should engage all levels of System governance and management. Only by continually reexamining the foundational questions discussed above, can Systems continue to achieve the value that led to their development in the first instance, and avoid ongoing management and governance stalemate, or even in the worst case, disruptive litigation.

J. Mark Waxman and Janice A. Anderson are Partners in Foley & Lardner LLP. Mr. Waxman is the Chair of the firm's Health Care Industry Team in the Boston, MA, office. Ms. Anderson is based in the firm's Chicago office.

END NOTES

1 *See, e.g.*, Modern Healthcare, *Systemic Attraction*, February 19, 2007; James E. Orlikoff and Mary K. Totten, *The Challenges of System Governance*, Trustee Workbook, Chapter 2, April 2006, Trustee (Center for Healthcare Governance).

2 For example, the new Progressive Health System combining Columbia St. Mary's and Froedtart Community Health in the Milwaukee area was announced on January 16, 2008 through the use of a Joint Operating Agreement.

3 *See, e.g., Achieving Scale Through Growth: An Imperative For Sustained Competitive Performance*, The Kaufmann Hall Report, Fall 2007.

4 Intra-System governance disputes also may reflect the trend. One example is the pending litigation between the Sister of Charity of Leavenworth and Exempla Health Care in Denver, Colorado, reported in MODERN HEALTHCARE January 7, 2008, at p. 18 and January 14, 2008, at p. 18.

5 While there is no precise definition for the word "systemness," in concept it means the integration or alignment of discreet entities with each other with a focus on achieving mutually desired benefits, such as economics of scale, market leverage, etc.

6 Changes in the use of charitable assets in and of themselves can be controversial and trigger litigation challenges. *See, e.g., Queen of Angels Hosp. v. Younger*, 66 Cal. App. 3d 359 (1977). When assets may be the subject of multiple oversight structures, e.g. the Catholic Church and the State, an additional degree of complexity may exist.

7 Post Trial Entry (PTE), at p. 2, *The Health Alliance of Greater Cincinnati v. The Christ Hosp.*, Case No. A0601969 (Ct. of Common Pleas, Hamilton County, Ohio. Apr. 16, 2007) (The Cincinnati Litigation).

8 PTE, at p. 4.

9 *Strategic, Financial and Capital Planning in a System Environment*, Report by Kaufmann Hall, 2008.

10 The Future of Healthcare Governance (1996); Center For Healthcare Governance, Trustee Workbook, April 2006, Trustee, *The Challenges of System Governance.*