

# SELLING FROM A POSITION OF STRENGTH

*A Charlotte, NC-based Congregation Gives Up Two Hospitals*

**L**ike some other Catholic healthcare systems, Mercy Health Services, based in Charlotte, NC, faced a dilemma in the early 1990s. Consisting of a 336-bed hospital in the city and a 97-bed suburban facility, the Mercy system was the smallest of three in its market. Although financially sound, Mercy was generating less revenue than its competitors and was attracting a smaller share of the area's managed care business.

Mercy's leaders initially responded to this dilemma by negotiating a collaborative relationship with the area's largest healthcare system. Before long, however, they decided that the partnership was unworkable and sold their system to the partner.

Mercy's story raises questions about the roles other Catholic healthcare systems will play as managed care continues to penetrate U.S. markets. Affiliations with other healthcare systems are one answer, but they do not always work. Some executives of Catholic hospitals are currently talking about following Mercy's example, said Richard J. Canter, a Milwaukee attorney who represented Mercy during the partnership and

eventual sale. Some hospitals will lose their Catholic identities as a result of such consolidations. "There will be some survivors. And some will leave the business," Canter said.

## SEARCHING FOR MANAGED CARE CONTRACTS

It was in April 1993 that Mercy's executives and board members began to talk about affiliating with another organization. "It was our sense that, given decreasing volumes and reimbursements, we were going to need to link up with someone—particularly someone with access to managed care," said Edward J. Schlicksup, the former president and chief executive officer of Mercy Health Services.

Mercy was then competing for managed care contracts with the Charlotte-Mecklenburg Hospital Authority (CMHA), a public system that was the area's largest, and the Presbyterian Health Care System. However, Mercy was handicapped in this because its downtown hospital was not full service and the system had a much smaller primary care base than its competitors.

"We had an income statement and balance sheet that were really strong in their own right," said Schlicksup. "But when managed care

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**Summary** In 1993 the leaders of Mercy Health Services, a two-hospital system in Charlotte, NC, decided to seek a collaborative arrangement with another organization. They did this because, although Mercy was financially sound, it was generating less revenue and attracting less managed care business than its two competitors.

In September 1994 Mercy's leaders signed a partnership agreement with the Charlotte-Mecklenburg Hospital Authority (CMHA), a public system that was the area's largest. Unfortunately, the agreement failed to integrate the two systems, so

they continued to behave as competitors. It was also clear that CMHA, having eight board members to Mercy's four, would dominate the partnership.

By early 1995 Mercy's sponsors, the Sisters of Mercy of North Carolina, had concluded that their presence was no longer needed in acute care in the Charlotte area. They and the system's lay leaders decided it would be best to end the partnership and sell their system outright to CMHA, which they did in June, for \$115 million. The congregation used that money to create a foundation that will provide services for the unserved and underserved.

companies came to town, they would typically approach one of the two big players." Such companies signed exclusive deals with CMHA or Presbyterian and in effect locked Mercy out of the market, Schlicksup said.

He said that Mercy's leaders first considered affiliating with one of several other Catholic systems. But although some of those systems could have provided Mercy with capital, they could not improve its access to managed care contracts, he said.

Mercy's leaders then discussed affiliating with other organizations, such as the Duke University Medical Center. Duke, which is in Durham, NC, about 150 miles northeast of Charlotte, is a regional provider with its own medical school. But an affiliation with Duke would have meant introducing still another player into the already crowded Charlotte market, said Schlicksup. So Mercy's leaders began looking for a partner closer to home.

#### MERCY PARTNERS WITH CMHA

In September 1993 Mercy's leaders decided to establish a partnership with CMHA. The latter's mission—providing healthcare service for everyone, regardless of income—appealed to Mercy's sponsors, the Sisters of Mercy of North Carolina, located in Belmont, NC, whose own mission is to care for the unserved and underserved. Presbyterian's mission was much more narrow, Schlicksup said.

A Mercy-CMHA partnership also made strategic sense. CMHA had a facility in the northern part of the Charlotte area, and Mercy had one in the southern part. Both systems' main facilities were in the central part of the city. Mercy's hospital-operated physician practices fit in well with CMHA's facilities. And CMHA, which had about \$650 million in annual revenue, was stronger financially than Presbyterian, whose annual revenue was \$300 million. (Mercy's own annual revenue was \$150 million.) "Overall, we felt the better fit was with" CMHA, Schlicksup said.

Leaders of the two systems signed a formal partnership agreement in September 1994.

#### CHALLENGES TO THE PARTNERSHIP

The partnership "sounded great on paper," Schlicksup said later. According to the agreement, Mercy and CMHA would keep their inde-

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pendence, each continuing to maintain its own assets, income streams, boards of directors, and management structures. Unfortunately, this mutual independence contradicted the systems' reason for becoming partners in the first place. "What we found was that we were still competing," Schlicksup said.

Mercy and CMHA needed to integrate—to consolidate services

and thereby cut expenses and share revenues—but the partnership agreement provided no plan for this, said Schlicksup. As a result, the two systems could easily agree to share a single laundry, but had much more difficulty doing the same with clinical programs. The partners had similar programs in open heart surgery, neurosurgery, and orthopedic surgery, for example. "There was a lot of overlap," Schlicksup said.

Under the partnership agreement, CMHA had eight members on a new joint board of directors, whereas Mercy had only four. "The larger partner wants to control more of the decision-making process," Schlicksup said.

During this period, Canter was involved in a planned consolidation of the two systems' medical rehabilitation services. The talks immediately focused on whether CMHA would dominate such a merger. It was becoming apparent that the partners operated from different perspectives, Canter said. "We stepped back and examined the entire relationship and what had gone into the initial decision to affiliate," said Canter. "We asked, Is this really going to work?"

#### THE DECISION TO SELL

Mercy's leaders considered three possible options, Canter said:

- Continuing a loose affiliation with CMHA, despite the partners' apparently different objectives
- Restructuring the affiliation so that the partners would have the same objectives
- Ending the arrangement

Mercy's leaders quickly decided that neither of the first two options was achievable. They briefly discussed whether they might have had more success with a different partner. "But it really boiled down to: How do you align strategic incentives with economic reality?" said Schlicksup. "No matter whom we were going to partner with, we

would run into the same problem."

Ultimately, he said, "we came to the conclusion that—given where Mercy was in the marketplace, given the changes on the horizon—it was in the interest of the congregation to leave acute care and redeploy the assets. It just made more sense to cash in your assets when you're on top, rather than waiting five years and being in a more difficult position."

Sr. Mary Jerome Spradley, RSM, then the president and CEO of the Mercy system, agreed with the decision. "I looked at this from the religious community point of view and realized there was an increasing difficulty in fulfilling our mission in acute healthcare," she said. "I had to stop and say, Is this where we belong? I felt the best option for the religious community, the healthcare organization itself, and the city of Charlotte was to sell."

"I think one of the mistakes a lot of us in religious life make is holding on to organizations and facilities beyond the point where they serve a real need," said Sr. Spradley. "Institutional survival becomes the issue, rather than meeting the needs of God's people. I think you have to be honest with yourself."

### THE SYSTEM IS SOLD

In January 1995 Mercy's leaders decided to sell the system to CMHA. A sale to Presbyterian was considered but vetoed because of perceived differences in the two systems' organizational missions. The leaders also rejected the idea of selling to a privately owned healthcare company because they did not want to bring another competitor into Charlotte.

Making the decision to sell involved a good deal of soul searching, said Sr. Pauline Clifford, RSM, president of the Regional Community of Belmont. "I think what we did was proceed very carefully," she said. "You just don't give up 100 years of a particular ministry easily."

Under the agreement the Mercy facilities will continue to bear the Mercy name for at least five years and will not perform abortions, but will no longer be Catholic institutions. Because they were concerned about the fate of their system's employees, Mercy's sponsors negotiated with CMHA a generous severance package for any Mercy employee laid off as a result of the sale.

There have been no layoffs so far, Sr. Clifford said. The congregation's leaders also were careful to explain the reasons for the sale to their members and to the general public. "As much as many groups loved Mercy, they understood what was happening and why," she said.

The sale was closed in June 1995. In return for the system, CMHA paid Mercy's sponsors \$115 million and agreed to assume \$28 million in long-term debt. The \$115 million has been used to fund the new Sisters of Mercy of North Carolina

Foundation, Inc., of which Schlicksup is now executive director and Sr. Spradley is president and CEO. The foundation has just begun deciding how to use the money, Sr. Spradley said recently. Grant-making guidelines are in the process of being completed, she added. The foundation's primary focus will be on programs and services for women, children, the elderly, and the poor—particularly those who are unserved or underserved.

In addition to the foundation, the congregation sponsors a hospital in Asheville, NC, and, in Belmont, NC, a facility for persons with AIDS and a residential center for severely disabled persons. "Our mission hasn't changed in terms of the healing power of Jesus," Sr. Clifford said.

### LESSONS OF THE SALE


The congregation and Mercy's managers deserve enormous credit for the care with which they considered their various options, including the option to sell, said Canter. "The sisters were willing to take a critical look at it, listen to the counsel of the management team and consultants, and decide what was the right way to go."

Canter praised Mercy's leaders for quickly recognizing the problems involved in their system's partnership with CMHA. After noting those problems, he said, they reexamined the objectives they had sought in the partnership and asked themselves if those objectives were still valid. Their answer being yes, they then asked themselves if they could do anything to make the partnership work better. This time their answer was no. Only then did they decide to sell, Canter said.

He also said, however, that he has seen partnerships like the one between Mercy and CMHA turn out successfully. "I have worked with other religious orders that started out with loose affiliations and continued the affiliation," Canter said such arrangements can work even when the Catholic organization has a weaker market position than its partner. To succeed, however, the partners must integrate their finances and management, he said.

Canter said the Mercy-CMHA partnership model—which does not require financial integration—may be obsolete in today's highly competitive environment. "I'm very much in favor of getting your foot in the door and seeing if you can live together first," he said. "But the marketplace has changed. You need a greater financial and operational integration to achieve cost savings."

Ultimately, he said, business partnerships are like marriages: It is up to the partners to make them work. "I think a partnership can work as long as there is a consistency of objectives," he said. □

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