The Sale Of Good Samaritan: A View From The Trenches

The management strategy behind one of the nonprofit hospital conversions in California.

by Molly Joel Coye

The board of trustees of the Good Samaritan Health System in San Jose, California, announced in September 1995 the impending sale of its four-hospital integrated health care system to Columbia/HCA. This was the first sale of a major nonprofit community hospital system in California to one of the emerging for-profit hospital chains. Coming close on the heels of the conversion of California’s Blue Cross plan, WellPoint, to for-profit status, and in the midst of rumors that the larger Sharp HealthCare in San Diego would shortly be sold to Columbia, the announcement was predictably controversial. Nevertheless, the sale was concluded in January 1996, with approval by the attorney general and a transfer of proceeds to establish the Good Samaritan Charitable Trust. Here I trace the sale of Good Samaritan from the board’s initial decision to pursue a strategic alliance, through the selection of a partner and the sale itself, to a review of Columbia/HCA’s performance in the San Jose market in the year since the sale.

Background

Good Samaritan was a “classic” integrated hospital-based system. A single corporate board governed four hospitals (a small rural hospital in Gilroy; an older, inner-city hospital in downtown San Jose; and two suburban hospitals, one large and one smaller). This board also was the sole corporate member of both the Visiting Nurses Association (the largest home care provider in the county) and the Good Samaritan Medical Foundation, a nonprofit subsidiary that held managed care contracts covering 70,000 lives and provided management services for the Good Samaritan Medical Group (a multispecialty group of forty-five physicians) and the Santa Clara County IPA (a large individual practice association of approximately 320 physicians).

The system had 4,000 employees, operated a total of 790 licensed beds, and had 1,400 physicians on its hospital staffs. Annual revenue in 1995 was $300 million. Management of almost all services had been consolidated among the four hospitals, and Good Samaritan had embarked upon a five-year plan to replace the existing welter of legacy information systems with a single integrated system. In fall 1995 the Good Samaritan Health System was named as one of the “100 Top Hospitals in the United States” in HCIA’s annual survey of hospitals’ performance in reducing expenses per adjusted discharge, lowering mortality, reducing lengths-of-stay, and increasing return on assets.

Consumer surveys in Santa Clara County found that Good Samaritan had the highest name recognition and the best reputation for quality among local providers.

Thirteen hospitals served Santa Clara County, including one for-profit (a small community hospital owned by NME, now Tenet),...
nine not-for-profits, two Stanford University teaching hospitals (adult and pediatric), and the county public hospital. Managed care had already driven hospital occupancy in the county below 55 percent. The Good Samaritan Health System—operating as Health Dimensions, Inc., until it was renamed for its flagship hospital, Good Samaritan, in 1994—had the greatest share of this declining market, at 22 percent of discharges. Despite this, Good Samaritan faced an uncertain future in this overbedded and highly competitive market, with its coffers depleted by acquisitions of a fourth hospital and the medical group several years before.

In spring 1994 the Good Samaritan Board of Trustees commissioned an independent study of the present and future countywide need for hospital beds. The resulting public report found that roughly half of the hospital beds in Santa Clara County would be unnecessary within five years. In the wake of this report, Good Samaritan organized an effort by the community hospitals to forestall the rebuilding of major sections of the county hospital, offering long-term access to excess community hospital beds at far lower cost to the taxpayers. When this effort was rejected by the county hospital and board of supervisors, Good Samaritan's board and many other observers concluded that hospitals in the region faced a long, painful, and unmanaged period of decline and increasingly bitter competition.

The Decision To Seek A Partner

In October 1994 Good Samaritan's Board of Trustees held a planning retreat to consider the system's prospects and strategic options in the local market. Although 1993 had been a good year for Good Samaritan, with a substantial recovery from earlier losses, it looked as if the system would barely break even by the end of 1994, and the projections for 1995 showed an urgent need to further cut costs or merge with a partner that could supply capital, cut operating costs, and help to leverage the market against price pressure from the health plans. Not surprisingly, Good Samaritan’s board concluded that it would be advantageous and perhaps even necessary to join with a larger partner.

The board had three explicit reasons for its decision to pursue a strategic alliance: (1) the consolidation of health plans in California and the need for leverage in an increasingly hostile market; (2) the capital requirements for physical plant rehabilitation, service consolidation, and information systems investment; and (3) economies of scale in purchasing and system development, such as information systems, combined with opportunities to borrow from broader experience in management and service development. There also was a “shadow motivation,” unspoken but always present: The board and the administration were increasingly convinced that Good Samaritan’s existing local, nonprofit structure would continue to make it difficult for them to undertake bold actions necessary for future survival. In the past year, for example, they had been unable to reach agreement on several key proposals, including the consolidation of cardiac surgery services, in large part because of the broad constituencies involved and the slow public decision-making process.

Acquisition by a health plan was attractive to the board because of its interest in “going upstream” to capture the fully capitated premium. This option was effectively precluded, however, by the realities of the northern California market: Acquisition by any single health plan would lead to disastrous retaliation by the other plans. The field was narrowed, therefore, to provider systems. There was no clear sentiment among the board members initially on the issue of a for-profit versus a not-for-profit partner, and the question was left open as the board headed into its evaluation of the options.

The Process

The Good Samaritan board authorized its executive committee to review other community nonprofit mergers and sales and to adopt a process for Good Samaritan. This included development of explicit criteria for the selec-
tion of a partner system; employment of an investment banking firm with experience in system sales and mergers to advise in the process; issuance of an extensive request for proposals (RFP) to potentially interested partners; participation by medical staff, medical group, and IPA representatives; and no public discussion until the board made its decision.

The initial criteria included financial strength, quality of care, community benefit, medical staff relations, experience with managed care, quality of information systems, and responsiveness to local conditions. In spring 1995 the board issued a full RFP and commissioned an independent valuation to give it a benchmark against which to consider offers. It was agreed that the medical group and the IPA would undertake independent discussions with each potential partner, because these physician groups saw the impending sale or merger of the system as an opportunity to rethink the physician/hospital structure. Specifically, they wanted the option to dissolve the medical foundation, which bound them exclusively to the Good Samaritan system for purposes of managed care contracting. Their principal competitors, the independent San Jose Medical Group, had the largest share of non-Kaiser health maintenance organization (HMO) enrollees in the region, and several other independent physician groups (Mulliken, Hill Physicians, and UniHealth) were reportedly poised to enter the South Bay market.

The candidates. Six potential suitors expressed interest: three for-profits (OrNda, Tenet, and Columbia/HCA) and three not-for-profits (the California HealthCare System, a regional network of four major hospital systems; Sutter Health; and Catholic Healthcare West). The latter withdrew because its recent merger with the Daughters of Charity system had given it two hospitals in Santa Clara with a market share of approximately 10 percent, and a merger with Good Samaritan’s 22 percent share would create antitrust issues. OrNda’s proposal for a management agreement was rejected by the board as outside the scope of the RFP. Sutter was in the final stages of merging with the California HealthCare System, so its offer represented the combined Sutter/California HealthCare System. At this point, the competition between Columbia/HCA and Tenet intensified. Columbia/HCA was especially eager to acquire Good Samaritan because it wanted a flagship institution around which to organize its northern California regional network; Sutter and Catholic Healthcare West had consolidated all of the other large hospital groups in the region. Tenet owned a small hospital in an affluent San Jose suburb and similarly saw Good Samaritan as a major entry into the northern California market.

As the board invited final proposals from the three remaining bidders, it began its own investigations of the candidates, together with the system executive and medical staff. In September 1995 the board announced that the Good Samaritan Health System had signed a letter of intent for purchase by Columbia/HCA and was entering final negotiations. The board notified the attorney general of the impending sale, outlined the nature of the transaction, and offered to meet to review the terms. The board also announced that the proceeds of the sale (after defeasance of outstanding system debt) would be used to establish a charitable foundation, which would become the largest health-related foundation in Santa Clara.

Public reaction. The public controversy that ensued in Santa Clara was considerably less than expected, and less than that attending similar sales of community nonprofits to for-profit chains around the country. Locally, this was probably the result of the board’s unanimity, the strong support by Good Samaritan–affiliated physicians for the sale to Columbia/HCA, and the fact that executives of the local county hospital did not oppose it (the chief executive officer of the county hospital testified before the state legislature that he did not think that the sale would have a significant impact on charity care in the county or on the hospital’s burdens).

At the state level, however, the history of HMO conversions and the recent conversion
of Blue Cross's HMO to for-profit status resulted in much more active concern. Neither the state hearings nor the attorney general's review raised direct criticism of the Good Samaritan transaction itself, but the legislature and advocacy groups expected an onslaught of similar sales (the sale or merger of Sharp HealthCare in San Diego to Columbia/HCA was already heavily rumored) and wanted a longer, more public review process with greater latitude for the attorney general. Legislation to this effect, Assembly Bill (A.B.) 3101, was enacted early the following year.

**The Immediate Result: Why Columbia 'Won'**

Columbia/HCA “won” because it offered more cash, greater community benefit, and comparable or better-quality care for the people of Santa Clara. The issue of greatest interest in this transaction is why the Good Samaritan board decided that Columbia/HCA's offer constituted a greater benefit for the community than Sutter/California HealthCare System's offer. In deciding whether to affiliate with a for-profit or a not-for-profit entity, the Good Samaritan board and medical staff evaluated several key criteria:

1. **Taxes:** Contributions to the local tax base from a for-profit partner would be approximately $4 million annually.

2. **Charity care:** Both Columbia/HCA and Sutter pledged to continue charity care at the same level that Good Samaritan had provided. Almost all charity care in Santa Clara is provided by the county hospital; charity care at Good Samaritan had represented only 1–3 percent of patient care expenditures.

3. **Academic programs:** Both organizations pledged to maintain the family practice residency program.

4. **Quality of care:** Both organizations had passed all relevant quality accreditation tests. Beyond this, the only concrete evidence of the quality of hospital care was offered by Columbia/HCA, which boasted an 18 percent commendation level on Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditations nationwide versus an average of 4 percent for all U.S. hospitals. Interviews with the medical staffs of hospitals in both of the candidates' systems by representatives of the Good Samaritan medical staff led to a preference by the medical staff, the medical group, and the IPA for the quality assurance processes and medical management used in Columbia/HCA institutions.

5. **Hospital services in the community:** Both candidates expressed their intention to maintain current Good Samaritan services, including the trauma center, cardiac services, and Medi-Cal (California Medicaid) contracting.

6. **Information systems:** Columbia/HCA routinely replaces the systems that already exist in newly acquired hospitals with a standardized information system and uses the resulting data to analyze and exchange information on performance indicators across the system. Sutter, in contrast, was embroiled in the same kind of extended, complex migration to a replacement information system as Good Samaritan had begun two years before.

7. **Physician relations:** The Good Samaritan Medical Group and IPA concluded that they wanted to be independent of each other and of any hospital-based system. Because the Sutter proposal would have drawn the Good Samaritan Medical Foundation into the larger network of Sutter medical groups, it would have maintained the physician/hospital organizational structure and nonprofit status that the medical group and the IPA were rejecting. The prospect of physician equity in the local system—a common element in Columbia/HCA's strategy for hospital acquisition—was rarely mentioned by Columbia/HCA during the discussions with Good Sa-
maritan’s medical staff and did not seem to be an important factor in the staff’s considerations. They were much more interested in what they perceived to be Columbia/HCA’s operating strategy: a combination of modern efficiency, massive capital infusion, and a return to the traditional “doctor’s workshop” understanding of the role of hospitals.

(8) Cost of care: Good Samaritan’s board believed that reducing the cost of care was both necessary for the system to survive and a benefit to the community. The board considered Columbia/HCA more likely than Sutter to be able to cut costs rapidly.

(9) Endowment of charitable programs in the community and continuation of Good Samaritan’s community benefit services: For many years Good Samaritan had devoted substantial financial resources—$750,000 and up—to providing community benefit services other than charity care, including a human immunodeficiency virus (HIV) services program, a series of ten school-based health centers, a community ministry, and a Meals on Wheels program. Because of Good Samaritan’s declining profit margins, these programs had already been cut and faced even greater cuts ahead. A sale to Columbia/HCA or Tenet would provide a long-term, steady source of funding for these services and for many others. Sale to Columbia/HCA would generate the largest endowment, yielding a contribution of approximately $2.5 million each year for charitable work in the community.

(10) Purchase price: The final competition between Tenet and Columbia/HCA was lively and led to enhanced offers from each. In the end, Columbia/HCA’s offer represented a higher purchase price. As a not-for-profit transaction, a merger with Sutter would have transferred Good Samaritan assets to Sutter and applied Sutter’s stronger credit rating to Good Samaritan’s outstanding debt; it would not have generated additional cash for community benefit purposes. Columbia/HCA purchased Good Samaritan, without the medical foundation (which was subsequently dissolved) for $165 million. After the defeasance of the system’s outstanding debt, this yielded $56 million for the establishment of the Good Samaritan Charitable Trust.

The Attorney General’s Review

Shortly after the announcement of the letter of intent with Columbia/HCA, and with the submission of the final terms of the sale, the attorney general approved the transaction. The sale of Good Samaritan to Columbia/HCA was completed in January 1996. The attorney general reserved two areas for further investigation. The first was whether the Good Samaritan board and administration had allowed the system’s financial condition to deteriorate in order to depress the purchase price. After an extensive review of Good Samaritan’s operating history and the economic realities of the hospital services market in Santa Clara, the attorney general found no basis for this concern.

The second question regarded the proper use of the proceeds of the sale. The approximately $56 million of residual proceeds from the sale of Good Samaritan were used to establish a charitable foundation for the health of the community. The Board of Trustees no longer has any operating responsibility for or connection to the hospitals, home care services, or other entities now transferred to Columbia/HCA. Board members cannot serve on any of the governing or advisory bodies for the new Columbia Good Samaritan Health System, and no distribution by the trust can benefit the Columbia/HCA system. Neither can the HIV support program, the school-based clinics, and the other heavily subsidized community benefit services maintain any preferential relationship with the new Columbia Good Samaritan Health System.

After some pressure from the community, public hearings were held by the board of the new Good Samaritan Charitable Trust to solicit program ideas from the community. The key issue under review by the attorney general is the latitude allowed by current law to the trust in defining its mission. The original mission of Good Samaritan, like most commu-
nity hospital systems, was mainly to provide acute hospital care. Both the board of the new trust and many community groups want an expanded vision that includes preventive and primary care services. The attorney general has yet to rule on the board’s plans for the trust.

The Mid-Term Result: Health Care In San Jose

At the end of the first year after the sale of Good Samaritan, the results for the community appear to be positive. The hospital system itself is flourishing: Volume has continued to grow, the replacement of the information system is well under way, Columbia’s national contracting clout has markedly reduced the expense of purchased materials, substantial capital has been invested in upgrading the facilities and acquiring new equipment, and strengthened relations with the independent San Jose Medical Group as well as the IPA have buttressed Columbia/HCA’s market position in negotiations with health plans. Initial layoffs of approximately 600 employees were drawn primarily from the corporate and administrative functions, as well as the management services organization supporting the Medical Foundation; only fifty came from patient care positions, and most of these have been rehired or replaced as hospital volume has increased. Columbia’s ability to draw upon comparative financial and operating data from its network of 300-plus hospitals has accelerated the pace of improvement of hospital services. Mid-level managers who continued to work within Good Samaritan after the sale to Columbia comment that the decrease in “cycle time”—the ability to analyze problems or opportunities, make decisions, and take action—and the increased delegation of authority and accountability within the hospitals have been the greatest operational changes.

It appears less likely that San Jose Medical Center, the aging downtown hospital, will be closed, and key community services such as the trauma center and the family practice residency have been maintained. The state contract for hospital care of the Medicaid population has been maintained, and Columbia Good Samaritan is an active participant in the development of Medicaid managed care services. The sale of the not-for-profit Good Samaritan Health System to a for-profit system has not decreased its provision of charity care.

Columbia/HCA appears to have played an interesting and positive role in the evolution of health services in the Santa Clara Valley. The underlying conundrum of excess hospital and physician capacity remains for Santa Clara Valley, however, as it does for the nation. While Columbia and other for-profit hospital systems can support expanded, competitive services with concentrated volume, other institutions that suffer from this competition have difficulty maintaining quality as their volume plummets.

Ultimately, the advantages of a more industrialized model of hospital operations—concentrated capital, enormous purchasing leverage, national and regional market strength in contracting, rapid diffusion of technology and best practices in management, and the standardization of processes for quality improvement—have made formidable competitors of Columbia/HCA, Tenet, and other large for-profit systems. These advantages may lead to the demise of independently operated hospitals, whether for-profit or not-for-profit. The reaction of health planners and regulators is often to try to thwart or manage this evolution. But most communities and states do not have the resources to maintain institutions with severely underused capacity, or the legal means to protect selected hospitals by eliminating excess capacity. In these cases, the overriding obligation of community hospital boards and political leaders is to ensure that access to care is preserved and that the financial benefit of these transactions accrues to the community.

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