



When Your Hypervisor Becomes Your Biggest Budget Problem

A healthcare IT playbook for the hospitals that have time to plan their VMware exit, and the ones that do not

For years, VMware lived in that comfortable category of hospital IT infrastructure that just worked, like power and cooling. It was essential, stable, and rarely a topic for strategic discussion. Then Broadcom completed its acquisition and rewrote the rules.

Healthcare CIOs are now receiving renewal quotes three to ten times higher than previous contracts. Perpetual licenses have vanished, replaced by mandatory subscription bundles that include products many hospitals never requested. For a standard 300-bed community hospital, an \$80,000 line item can suddenly become a \$400,000 commitment.

What is catching leadership off guard is not just the size of the increase. It is the permanence. Under Broadcom's model, hospitals are not just paying more, they are being forced into five-year commitments at prices many organizations cannot absorb without cutting elsewhere.

This is no longer a routine procurement event. It is a strategic inflection point that demands a deliberate response. The good news is that hospitals do have options. They are not all easy, but they exist, and the earlier you start, the more of them stay open.

Hospitals do have options. The renewal will happen, and if you do not start anticipating this a year or two beforehand, you will have no option but to pay.

Why this hits healthcare harder

Independent industry reporting confirms what hospitals are seeing firsthand. VMware licensing costs have increased 300 to 1,000 percent following Broadcom's acquisition, with perpetual licenses eliminated and bundled subscriptions required. For healthcare organizations running thousands of cores, this is not a rounding error. It is a seven-figure budget event that compounds every year it remains unresolved.

The result is a simple but uncomfortable truth: continuing on VMware at current pricing may no longer be financially viable for many hospitals, regardless of how stable the platform once was. Each organization needs to study its own situation, but the math is rarely flattering.

Unlike commercial enterprises that can rapidly shift workloads to public cloud, hospitals operate under specific constraints that make a rip-and-replace strategy dangerous. I see three friction points in nearly every engagement.

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- **Rigid hardware and budget cycles.** Hospitals rely on five-to-seven year depreciation schedules. You cannot simply discard two-year-old servers to fit a new licensing model. Unexpected six-figure IT increases compete directly with clinical staffing and life-saving equipment.
 - **Latency-sensitive clinical systems.** Imaging systems and real-time monitoring tools assume low-latency connections. Moving these to the wrong cloud architecture can introduce lags that radiologists and clinicians cannot accept.
 - **The “if it isn’t broken” legacy.** Many clinical systems were never designed for virtualization and were stabilized on VMware through years of careful tuning. The institutional knowledge of why those configurations exist often left the building years ago.

Step 1: Optimization is your first defense

The most immediate move is not a migration. It is infrastructure optimization. In my hospital infrastructure assessments, I frequently find servers running at 20 percent utilization and zombie VMs consuming licensed cores that have not been touched in months.

Before you negotiate or migrate, execute a four-week cleanup sprint.

- **Inventory.** Map all hosts and cores against actual utilization data.
- **Right-size.** Aggressively consolidate VMs. Optimization alone can reduce licensed cores by 20 to 40 percent. In large hospital environments, that reduction often translates into hundreds of thousands to millions of dollars in immediate cost avoidance, before any migration even begins.

This creates a clean baseline for comparing your actual alternatives. It also creates leverage. The conversation with Broadcom changes when you can document that your real footprint is meaningfully smaller than the renewal quote assumes.

Step 2: Choose a migration path that fits clinical reality

At this point, the question is not which platform is most familiar. It is which options remain financially sustainable under your operating constraints. There is no single right replacement. The optimal path depends on your hardware lifecycle, your application portfolio, and your risk tolerance.

Option A: Stay on-premises with Microsoft Hyper-V

If you recently refreshed your hardware, a full cloud migration is likely not fiscally viable. An on-premises hypervisor swap is usually the path most hospitals can defend financially.

Microsoft Hyper-V is the destination that hospital environments should not overlook. It is often included in existing Microsoft Datacenter licensing, integrates cleanly with the Active Directory and Windows infrastructure already running in the hospital, and pairs with Azure for future hybrid moves. The operational pattern is familiar to teams already running Windows Server at scale.

Other converged technology solutions exist as alternatives, with multiple vendors capable of supporting hospital environments. The trade-off worth naming: those vendors are also operating in a market where Broadcom's repricing has reset expectations, and they may not be able to hold pricing over the long term. Some of these options also require significant capital investment up front. They can work as short-term off-ramps, but the long-term math is harder to predict than Microsoft's, where the relationship and pricing model are well established.

Option B: The hybrid cloud approach

Although a full cloud migration is the long-term destination for many healthcare systems, it is complex and disruptive to execute as a wholesale rip-and-replace. It needs to be planned, will delay savings until completed, and is not a project to rush. Instead, align cloud migration with your hardware end-of-life cycles.

- **Dependency mapping.** Document which clinical applications must move together to avoid breaking integrations.
- **Move first.** Low-risk, non-clinical workloads like administrative systems, internal tools, and analytics that can tolerate performance variations without impacting care delivery.
- **Keep on-prem (for now).** High-volume imaging, legacy apps with complex device integrations, and latency-sensitive clinical systems.

Done poorly, a rushed cloud migration can replace VMware cost shock with unpredictable cloud spend, compounding the financial problem instead of solving it.

Overcoming the vendor support block

A common blocker I hear is the application vendor saying they only support VMware. Often, this simply means they have not tested on other platforms, not that the application will not work.

Hospitals have more leverage in this conversation than they realize. You are the customer. You have options, including not renewing the application contract. Use that as leverage rather than treating vendor reluctance as a final answer. To de-risk the conversation:

- Ask if they support the underlying OS (Windows Server or Linux) regardless of the hypervisor.
- Stand up a test instance on your new platform and invite the vendor to validate it with you.
- Engage a consulting partner who has already successfully migrated that specific application in other hospital environments.
- Make clear that ongoing support is a renewal criterion. Vendors that refuse to test on alternative platforms are signaling something about their product roadmap that you should factor into your decision.

Step 3: Combine the desktop decision with the hypervisor decision

Your VMware problem is likely colliding with your Windows 10 end-of-support problem. Instead of fighting two fires, consider combining them.

Moving to a lower-cost virtualization layer can create an opportunity to expand Virtual Desktop Infrastructure. Moving from physical desktops to VDI lets you upgrade the OS in the data center rather than touching every endpoint individually. This modernizes desktop lifecycle management while solving the hypervisor licensing problem in the same project.

This is one of the few cases where the renewal pressure can produce a better long-term outcome than the status quo would have. Two competing infrastructure deadlines turn into one coordinated modernization, executed once.

Your 5-phase replacement playbook

If your renewal is 6 to 24 months away, you have time to turn this crisis into a modernization opportunity. Here is the high-level shape of the work.

- **Assessment (Weeks 1-6).** Quantify zombie workloads and map clinical dependencies. Produce the workload inventory and the cost model the CFO needs to understand the decision.
- **Optimize (Weeks 4-10).** Right-size VMs to present Finance with a lean renewal cost versus the bloated current state.
- **Build and test (Weeks 10-22).** Stand up the alternative hypervisor environment. Validate performance with non-clinical workloads first.
- **Migration roadmap.** Prioritize workloads based on maintenance windows and clinical impact, not just technical ease. Sequence around clinical operations the same way you sequence other change.
- **Capability building.** Treat this as a long-term shift toward a flexible, multi-platform healthcare IT infrastructure rather than a one-time project.

If you have time, use it. If you do not, the optimization sprint alone is worth running before the renewal lands. Every week of preparation is leverage you cannot recover later.

A catalyst for modernization

Broadcom's pricing strategy is unlikely to reverse. It has fundamentally changed the financial equation. For many hospitals, renewing VMware at current rates is no longer economically defensible, even though every situation deserves its own study.

Waiting reduces the time you have to right-size your environment and plan an exit. Hospitals that act now, optimizing first and testing alternatives early, are turning a painful cost shock into an opportunity to regain control of their infrastructure roadmap.

T2 Group specializes in guiding hospitals through these transitions. We understand the constraints of 24/7 clinical operations and can help you reduce VMware cost without compromising patient care continuity. Our two services, project leadership and governance and technical migration execution, can be engaged independently or together. On qualifying engagements, we offer a shared-risk pricing model that ties a portion of our fees to your documented savings.

Your renewal is coming. Let's reset the math.

30-minute scoping call with a T2 Group migration lead. No deck, no pitch, just your environment and your timeline. Visit t2group.com/save-the-renewal-lp to schedule.

About the author

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Sources

CIO.com, "VMware licensing and pricing hikes: What options do you have?" (2024).