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The Management Bandwidth Problem

By Jeff Goldsmith
Mergers and acquisitions aren't the answer to positioning for health reform.


Jeff Goldsmith

Never try to catch two frogs with one hand. This ancient Zen aphorism applies perfectly to the situation health care management faces right now. Health reform has created remarkable uncertainty. Given the up-front financial "contribution" to health reform (through reductions in hospital payment updates and disproportionate share hospital payments) and the threats from Medicaid funding crises and future federal deficit reduction, the path to payment reform outlined in the Patient Protection and Affordable Care Act is difficult to predict.

Because congressional and administration policy-makers did not know what to do about payment and delivery system reform, they authorized CMS's Innovation Center to do about 20 things and gave the agency more than $10 billion and 10 years to do them. The roster of potential payment reforms is a veritable stampede of hobbyhorses — pet ideas, some decades old, of policy entrepreneurs in academia and at foundations. Many are targeted at chronic diseases, while others encourage salaried employment of physicians, nonphysicians doing physicians' work, and clinical management by the numbers.

However, one hobbyhorse has been given pole position: the accountable care organization. Read the legislation carefully and you will discover the ACO is not a demonstration or pilot; it's part of the law. Shortly, you have what will be an open option to get together with your physicians and apply to launch a communitywide gain-sharing program for your Medicare patients. Several years from now, if you can manage to "bend the trend" (yet to be defined), you might pocket some savings to share with your partners in cost containment.

Upswing of Mergers and Acquisitions

There are dangerously inflated expectations in some corners of academia and the policy community that the ACO might be the "escape fire" from fee-for-service. This seemingly innocent gain-sharing program has the potential to consume billions of dollars and end the careers of a generation of thoughtful health care executives and physician leaders.

This is because health care executives have reacted to the seeming inevitability of this still-hazy policy idea with a spasm of merger and acquisition activity. Without carefully weighing the consequences, hospitals and health systems have started a spate of physician practice acquisitions that dwarfs the disastrous practice acquisition splurge of the mid-1990s. A new wave of hospital mergers has been launched as well. (Remember Stanford-UCSF, University of Cincinnati-Christ Hospital, Mt. Sinai-NYU and a host of other shotgun marriages.)

The rationale for the new wave of industry consolidation is that unless you align incentives with physicians — meaning "you docs work for us now and we can tell you what to do" — and achieve mass and scale (e.g., private health plans have no choice but to fund your integration losses), you won't have

enough control to manage communitywide health costs. I think these are both dubious propositions, and there's a lot of historical evidence to back me up.

Those with long memories will recall that the industry has thundered up this particular box canyon before in the 1990s, because we believed the Clintons were going to bring us closed panel capitation. The industry beat a hasty retreat in the late 1990s in the face of billions in operating losses, angry boards and catastrophic damage to hospital/medical community relations. Perhaps fewer than one in 10 hospital systems actually created successful (self-sustaining and self-governing) physician/ambulatory operations, and a handful actually created successful health plans. Many of those successful provider-sponsored health plans left the existing structure of medical practice intact, relying on independent practice associations to achieve clinical discipline.

Unfortunately, the institutional memory of that integration fiasco lies with executives and board members now long departed, so old discredited strategies like physician/hospital organizations and vertical integration seem new again. What we should have learned from the 1990s is that mergers and acquisitions create political crosscurrents inside organizations — power struggles, management turbulence, and turnover that consumes a huge fraction of senior management and board time and attention. It seemed like the improvements in service quality and safety and the capacity to manage care that were the intended consequence of these activities never happened because so much of management bandwidth was consumed in merger-and-acquisition-generated organizational turmoil.

This time is different. The economy is in far worse shape, and demand for services has been slack for several years. There are fewer degrees of freedom to fail than there were 15 years ago. And while the ACO thing is playing out, many hospitals will see their Medicare and Medicaid populations double as a result of health reform and the enrollment of baby boomers in Medicare. We can be confident that unit payment from both programs will not keep pace with inflation, sapping cash flow at the worst possible time.

Better Responses to Financial Stress

So what do hospitals and health systems have to do to respond to these financial pressures, and who will do it?

- What about getting clinical IT right — not just being "meaningful users," but actually improving clinical productivity, communications inside the care team and the care experience itself?

- What about getting control over costs and actually managing them, particularly the complex, big-ticket costs like implantables, employee benefits (yes, your own health expenses) and specialty pharmaceuticals? Getting to the point where hospitals and health systems can "run on regular gas" is a vital precondition of *having* a future in health care delivery.

- What about getting the hospitalist/intensivist thing right, not just bailing out your private practitioners who don't want to come to the hospital anymore, but actually improving co-ordination and accountability for resource consumption?

- What about finally getting customer service and care transitions right so your patients don't have to bring a family member with them to manage the process, but rather all patients reliably get the right care and families the right support at the right time?

- What about getting the medical home right? ACOs or not, hospitals are going to absorb a huge fraction of the primary care business in their communities from retiring docs. Simply taking primary care docs and their office staffs on salary will not solve the problem of a broken primary care model.

Make no mistake. All these things are going to be necessary to succeed as an ACO. But if all management is doing is putting out fires started by merger and acquisition activity (aligning and bulking up), I guarantee most of them will never happen. There is a strict limit as to how much time senior managers and their direct reports can apply to any agenda. Managing the senior team's bandwidth and having clear accountability for improved performance will not happen without leadership and focus. Never try to catch two frogs with one hand.

Finding the Right Scale

It's a great time to ask some strategic questions. For example, do you need to own all the docs in the community to manage your own costs, transition to bundled payments, or manage communitywide costs? Which docs do you need to own versus which docs want you to own them? Do you need 100 percent hospital market share versus 30 percent or 50 percent to bear and manage clinical-cost risk? How much risk do you feel compelled to assume and how much can you assume with the scale and relationships you already have? Will the private health plans in your area (the source for 120 percent of your profits) play along?

The reality is that most medium-sized and larger systems will run out of money before you employ all the docs in your communities, and the Department of Justice and FTC might have something to say about your having 100 percent market share. In the end, sorting out how much you need to own and control is as important as getting the infrastructure, management culture and physician leadership parts right.

As one financial sage said on CNBC the other day, "In the business world, it's either do deals or run the business." This latter challenge is even harder because the business is changing. The implication is that no one ever does both right at the same time. If management follows its imperialistic instincts, its "sense of adventure" as a colleague from the 1990s once put it, the tragic result might be that the hard work of changing how care is provided and putting our institutions on a sound operational footing may never get done.

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