PERSPECTIVE

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Welcome to our first issue of *Leadership Perspectives*, an ongoing publication with the goal of providing personal commentaries from your peers on the important, pressing issues impacting academic health centers. These essays are meant to both stimulate discussion and engage academic health center leadership in a thoughtful dialogue.

When we surveyed academic health center leaders a few months ago and asked them essentially what keeps them up at night, two issues rose to the top: market consolidation (and clinical funds flows) and funding research. Early results from the survey showed that 41% of the respondents are undergoing major expansions of their hospital or physician network. Hence, it is entirely relevant that this inaugural issue focus on market consolidation, offering three views of academic health center leaders. Their institutions, based in New York City, Houston, and Mobile, offer a representative sample of AAHC membership and organizational models.

Bob Grossman at NYU cites the lessons learned from past merger attempts, such as Stanford-UCSF and NYU-Mount Sinai. He cautions us to be "buyer beware" in that mergers have real costs and often little in the way of short-term results. Paul Klotman from Baylor, while pointing out that consolidation is not a new phenomenon, emphasizes that market size really does matter and that efforts to preserve the mission can be the hardest part. Ron Franks of the University of South Alabama notes that cultures do not often easily blend in merger/consolidation efforts and that academic health centers are at particular risk in the provision of "commodity care"—defined as routine, high-volume services.

It's clear that clinical market consolidation is an effort to enhance provider power, but often results in a challenging mix of cultures, priorities, and leadership styles. Our members are preparing for the era of no more open-ended funding by developing tools to assess efficiency; implementing an integrated, interprofessional vision; broadening their understanding of the scope of their activities; and preparing to assume more financial risk for the health of the populations they serve. In this context, market consolidation must be viewed more as an opportunity than a threat. We are living in an era where "collaboration is the new form of competition." In this context, market consolidation can be viewed as supportive of collaboration, but only if all the parties understand that it is necessary to give up some power to achieve the greater goal.

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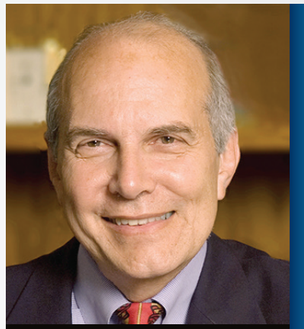

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Robert I. Grossman, MD // *Dean and CEO, School of Medicine*
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While today we see some acceleration of consolidation in the healthcare market, if you go back to the 1990s when we had managed care, there were also a lot of mergers going on then. NYU had a merger with Mount Sinai. Stanford had a merger with UCSF. Geisinger had a merger with Penn State. There has long been M&A activity in healthcare and at academic health centers.

The ideal merger would be to take two units and fully integrate them—merge their leadership, create synergies, and completely integrate all their functions. But realizing all the efficiencies and economies that mergers promise is very difficult to achieve. Blending institutional cultures is critical. I don't know many places that have really done that. If cultures don't mix, that trumps any merger strategy.

Moreover, mergers may not actually add as much value as people anticipate. Some supposedly great deals turn out to be not so great if you really look at them. Look at the experiment of UCSF and Stanford combining and later separating. I think the separation of those two actually added more value to each institution than the previous combination. Similarly, a review of the separation between NYU and Mount Sinai that followed their merger shows both institutions are doing much better now than they were doing, or likely would have done, in the aggregate. I would argue that the question of whether mergers necessarily produce better institutions is worth discussing.

My advice for those who are bent on doing mergers is "buyer beware." Make certain that you do understand and do not underestimate the risks and costs of integration. It is very difficult to conduct a successful merger. You have to first take into account what each institution might achieve on its own without a merger, and then consider what the outcome or value proposition of the proposed merger might be. Managing the merger, truly creating efficiencies, and uniting cultures takes an incredibly long time and lots of hard work. IT systems, electronic health records, and the countless other components of infrastructure have to be united, so there are tremendous integration costs. Then there is the dyspepsia, distractions, and dysfunctions that come with mergers—those things extract an enormous toll on an organization.

Finally, remember that you don't see the results in the short term. You may not even see them in the long term. When mergers do not work, you can lose hundreds of millions of dollars, not to mention the negative psychological impact of setbacks for the participating institutions. So you have to be very careful.

> "…Mergers may not actually add as much value as people anticipate."

Paul Klotman, MD // *President and CEO*
Baylor College of Medicine

What is happening today in terms of consolidation is not much different from what happened in the 1980s around HMOs. The tendency has always been that bigger must, by definition, be better. I think what we are seeing today is that same rush toward size.

One guideline seems to be that systems with top-line revenue below $3 billion are on the verge of being too small. There is a push to combine systems through mergers to get above, say, $6-9 billion in overall revenue. Systems of that size can mitigate some of the risks of a changing marketplace.

This is a big concern for academic health centers. Most of them are well under $3 billion in top-line revenues. Many have small hospitals. Even the bigger ones aren't that big. So what do you do? Do you partner with a bigger system? For places that have traditionally had total ownership, and have not been used to partnering, that's a significant cultural shift.

I think academic health centers are going to have to really look at their survival opportunities. Are they the dominant player in terms of market share in their community? Can they protect themselves if payers want to redirect patients? They need to have very tough conversations internally. How do we focus on value? What happens if everything we do is really an insurance product? In a large clinically integrated network model, if the margins are in the premiums, and doctors and hospitals become the expense, how can academic health centers position themselves so that they still get revenue?

Many academic health centers have lived on the high margin of medicine—for example, emphasizing quaternary services—and haven't focused as much on becoming value-based. But in today's market, they are going to have to become that provider. In other words, can they provide high-quality services at the lowest costs? If they can reinvent themselves to provide the best outcomes at the lowest costs, then everyone will to want to work with them.

The hardest part of structuring these financial deals, though, is making sure that you build in provisions that will help you preserve your mission. As we try to get bigger or figure out a way to get access to a larger market, how do we make sure that we draw lines around our core missions of education, research, and community activity? We need to make sure, as we deal with the finances, that we don't lose focus on those priorities.

> "The hardest part...is making sure that you build in provisions that will help you preserve your mission."

Ronald D. Franks, MD // *Vice President for Health Sciences*
University of South Alabama

In the future, we are likely to see more consolidation of physicians and hospitals within systems that can produce revenue streams adequate to develop the infrastructure needed to monitor the health outcomes of patient populations. At the University of South Alabama College of Medicine, we are further integrating the physician practice with the hospital practice and also working closely with the Federally Qualified Health Centers in our community.

This kind of relationship is a natural fit and, in order to maximize Medicaid dollars, one we will need to improve as we move towards managed care. However, we had previously tried a closer, comprehensive affiliation with a community hospital. Despite everyone's best efforts, the cultures just could not blend. For example, their hospital system had no significant educational programs, so it became difficult to find common ground with our educational mission.

Academic health centers have a problem: Because of cultural differences, they may not fit in easily with community hospitals—or vice versa. Maybe financial circumstances will be desperate enough to force them to find common ground, but it is very hard to blend different missions. As a comparison, we are exploring the development of a closer, more formal relationship with the University of Alabama at Birmingham. Even though they are 200 miles away and are a larger institution with more robust clinical and research programs, our cultures are well-aligned. When it comes to partnerships, as they say, "culture eats strategy for lunch every day."

Another area where academic health centers are at risk is in what might be called commodity care—routine care where physicians have to see a lot of patients as efficiently as possible. That approach does not lend itself very well to a good teaching environment because teaching takes time and slows processes down. Someone has to pay for that. But insurance companies are focused on getting care as inexpensively as possible. If academic health centers are not able to compete on the price of everyday care, they are likely to focus more on specialty, tertiary, and quaternary care.

What's unknown is whether insurance companies will pay added premiums for those unique services. Or, in this evolving market, will insurance companies cherry-pick where they send patients, perhaps concentrating everyday services at community hospitals and then use academic health centers only for specialized services? How will payers structure payments for subspecialty and super subspecialty services? In such an environment, what kind of negotiating power will academic health services have? All these issues move us into an area that we have not had to deal with before.

> "[Another risk is] commodity care—routine care where physicians have to see a lot of patients as efficiently as possible."