Joe Hoffman was a top cop in New York. Now, as the head of Bay State Health Care, he has an even tougher job: controlling the doctors of Massachusetts.

By Alexander Wright

For Joe Hoffman, fate presented itself early one Sunday morning in 1978, wearing the angry, screaming face of a Brooklyn mob.

Hoffman was first deputy commissioner of the New York Police Department, second in command of the 25,000-man force. He was accompanied by newly elected mayor Ed Koch to a meeting of the Hasidic community in Brooklyn, a gathering held to mourn—and to protest—the street killing of a Hasidic Jew the night before.

After a few routine questions from the crowd, followed by the usual conciliatory platitudes from the mayor, what had started as an informal Q-and-A session began to look more and more like a mob scene. Soon, the hostile crowd was pressing in, closer and closer, cutting off all avenues of retreat.

“That was the day,” recalls Hoffman, “that Ed Koch and I got to be very, very close.”

They both made it out unscathed. But in the thick of the tension, the two men—the brash, outspoken mayor and the buttoned-down, up-through-the-ranks police commander—had forged a quick friendship.

“It was a little like being in battle,” recalls Hoffman. “It was that kind of a bond.”

Several weeks later, Koch asked his new friend Hoffman to accept a job as president of the city’s Health and Hospitals Corporation.

Hoffman was a curious choice, to say the least, for what was arguably the most important health-care job in the country. He was a cop, after all: a former city patrolman who by his own admission knew next to nothing about medicine. A man whose one ambition was to follow in the footsteps of his hero, Patrick Murphy, former mayor John V. Lindsay’s reform-minded police commissioner. But Koch had other ideas.

When Koch was asked to explain his criteria for choosing Hoffman, the mayor came up with a simple reply: “He knows how to balance a budget.” And so he did.

In the decade following that morning in South Brooklyn, Joe Hoffman spent his time learning what most doctors would rather forget: that the future of American medicine rests less firmly in the deft fingers of surgeons than it does in the heavy, graceless
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from medical professionals, who worry that shifting priorities within the health care industry will jeopardize the quality of care. These businessmen may know all there is to know about balancing budgets, goes the common refrain, but what do they know about medicine?

As one prominent senior neurosurgeon at the Massachusetts General put it: "The trouble with Bay State is the trouble with all of these so-called managed-care outfits: The problem is that they're not managing 'care' at all. What they're managing is finance."

Hoffman prefers to take a more sanguine view of things. "I've always said that good medicine is cost-effective medicine," he says. "If we can control our costs, then ultimately everyone benefits."
Spoken like a true administrator. From a managerial point of view, the principle is a sound one: Lower operating costs mean higher profit margins, better service and lower costs for the customers. Everybody wins. Right?

Well, maybe not everybody. Absent from this tidy little equation are the health-care providers themselves: the doctors and hospitals who ultimately foot the bill when medical care gets sold off at a bulk rate.

Over the last few years, Bay State has earned a reputation among medical providers as something of an administrative skinflint, relying on its size and managerial muscle to cajole physicians into controlling their costs and to nudge hospitals into touting the administrative line.

Lately, health-care providers have been taking Bay State to task for its vigorous devotion to cost control. The providers say they’re being asked to foot the bill for Bay State’s balanced budget.

Hoffman says Bay State’s providers need to take a broader, more inclusive view of things. “Working in the context of managed care demands that we impose certain restrictions,” he acknowledges, candidly enough.

When Hoffman arrived at Bay State’s Kendall Square headquarters last year, he assumed control of a company that had only recently begun rebuilding itself from near-total collapse.

After promising early growth following its official state licensing in 1978, Bay State started to feel the growing pains of a kind of administrative adolescence: Bay State’s fiscal body was outgrowing its administrative mind, so to speak, and that meant trouble.

Bay State was originally formed as the physician community’s response to the coming of the bean counters. Harvard Community Health Plan, started in 1969 as an experiment by Blue Cross and Blue Shield of Massachusetts, began to take off, to the alarm of doctors throughout the region. Harvard Health, you see, had taken the independence out of independent practice. It built health centers and hired doctors—salaried employees, answerable to corporate management.

Bay State would be different. It was founded by doctors, with doctors on the board of directors and doctors running the company. Physicians would continue to practice in their private offices, joined together in a loosely formed network to stem the flow of patients out of their offices. Bay State told subscribers it offered the best of both worlds: the cost savings of an HMO, combined with the freedom to continue a relationship with a family doctor who practiced in a traditional small-office setting.

From 1978 to 1986, the plan’s subscriber base shot up from ground zero to a total of 140,000. The growth came so rapidly that the administration couldn’t keep up the pace.

The claims were coming in faster than Bay State could pay them.

Central to the problem was a badly overworked management information system—an operation obviously vital to such a data-dependent operation—that was struggling and sputtering, hopelessly underfunded and overstressed.

But there was more to the problem than simple administrative myopia.

Then-president Gary Janko and his high command had a good thing going with this managed-care business, and they knew it. They thought they could parlay it into something bigger.

Bay State Health Management, a for-profit management company, was founded in 1986 with the hope that it would someday evolve into a self-sufficient managerial entity that would be free not only to manage Bay State’s accounts, but to branch out into other markets and administer other network-model health plans around the country.

Bay State remains to this day a for-profit concern. Even though the plan itself (the fund out of which all claims are paid) is a nonprofit entity, the company’s managerial arm—which pays all 640 of Bay State’s salaried employees—separately incorporated as a profit-making operation.

Bay State Health Plan is the exclusive client and sole shareholder of Bay State Health Management, a technically distinct organization that deals in a single service with a single client: managing Bay State Health Plan. Together, the two entities make up what is known as Bay State Health Care.

Janko and his brain trust harbored grand visions of national expansion. They dreamed of someday even taking on the big boys at Blue Cross. With such grand ambitions, Bay State entered into a managerial relationship with a health plan called Physicians’ Health in Shreveport, Louisiana. It was to be the trial run for an eventual push at the national market.

The relationship proved a failure. Within two years, Bay State had pulled out and given up on going national.

Meanwhile, back on the home front, things had also soured. While Janko and company had been chasing their dream of national expansion, they had lost sight of the problems at home. By 1986 the plan was floundering amid mushrooming deficits and misguided management. It was the year Bay State scraped bottom, with expenses exceeding revenues by a total of $13.8 million.

Bay State was running a managed-care plan with no management. The practice of medicine was changing, but the doctors on the board and in the executive offices were unable—or unwilling—to force their member physicians to change their ways. Bay State physicians were hospitalizing their patients at a far higher rate than their competitors were, driving up costs and threatening the health of the plan.

Thanks to a nifty little accounting trick, Bay State was able to stay alive by writing off those losses with moneys it had withheld from its doctors over the years in a special reserve fund.

The moneys had originally been withheld under provisions of something called a “risk fund,” which existed for just such purposes. Under provisions of their contracts, doctors who signed up with Bay State agreed to let the company withhold 30 percent of their agreed-upon fees, with the understanding that if the plan performed well at the end of the year, they would receive some or all of their money back.

The flip side of the equation also held: If Bay State performed poorly, the withheld moneys would be used to offset losses.

The idea was that by tying the doctors’ payments to the financial success of the plan, the doctors would have a built-in incentive to control their own costs. But the plan was losing money so rapidly that no money had been returned to the doctors in two years.

Hoffman’s charge is to restore order to Bay State’s budget and image.
In 1986 Bay State acted. It changed the name of the withholding plan from the risk fund to the "utilization incentive fund."

"Utilization" is the industry code for "hospitalization." It is a curious choice of phrase, and in many ways an instructive one: one of those sanitary idioms that tend to thrive in the corporate vernacular. Thinking in terms of "utilization"—rather than, say, "healing"—affords budget-minded managers the clinical comfort of reducing to a calculable statistic the otherwise mysterious healing processes of the human body. In this case, the choice of terms is downright misleading, the fund is actually a "non-utilization incentive fund," rewarding physicians only if they keep their patients out of the hospital.

The function of the newly named fund was basically the same, only more explicit: to encourage doctors to keep their costs down.

By calling it an incentive fund, Bay State no longer had to write off the fund as a liability, thus relieving some of the strain from its ledger.

For the doctors, of course, it didn't make much difference what Bay State chose to call the fee—they still were getting only 70 cents for every dollar they billed to Bay State.

Bay State, "the doctors' plan," self-appointed savior of independent physician-entrepreneurs, was instead wrecking their practices.

By the beginning of 1987, Bay State was a mess. On March 12, Janko tendered his resignation. All of his senior administrators soon followed him out the door.

In 1987 Bay State dipped into the reserve fund once again, this time using $23.3 million of its doctors' money to offset its losses, managing to show a gain of $2.4 million for the year.

By this time, Bay State's board of directors realized that it couldn't carry on this way for much longer without its doctors muttering. It needed a fresh start, but the board knew it was facing a serious problem: how to attract quality management to an operation that was losing millions annually.

Enter Paul Lazzaro, a Harvard Business School graduate whose specialty was corporate turnarounds. In 1987 Lazzaro and his partner, William Henry, a former oil man, signed a contract to overhaul Bay State's entire operation.

At the time, many health-care observers questioned Bay State's wisdom in choosing the Lazzaro group. Lazzaro and his partner had never worked with a health-care organization before. Critics also questioned the astronomical salaries that Lazzaro and Henry had bargained for—reportedly in the $2 million-to-$3 million range, according to a report published in the Quincy Patriot Ledger based on the company's public filings.

Even by the high-priced standards of corporate consulting, the Lazzaro group's fee was considered extravagant. Its seven-figure fee, after all, was larger than the amount of the 1986 deficit that had prompted its hiring.

Under the terms of the deal, Paul Lazzaro assumed the presidency and directly oversaw sweeping changes in the management structure. There were wholesale firings and clamp-downs on collections and claims-verifications policies.

The Lazzaro group's chief priority was cracking down on an obscure but all-important statistic: the utilization-time ratio. Simply put, the ratio measures the number of hospital days Bay State pays for per 1000 subscribers. By scrutinizing claims more closely, Bay State had brought that number down from a dizzying 539 in the first quarter of 1986 to 488 in the first quarter of 1987. Lazzaro slashed the number of hospital days per 1000 subscribers even further, to 439, in the same period for 1988: a reduction of more than ten percent. (Since then, the figure has continued to decline, down to 426 for the final quarter of 1989.)

The Lazzaro group's high fees and sweeping overhaul were ultimately vindicated by the group's success at turning Bay State around. By 1988 Bay State was making money again, with its "revenues in excess of expenses" totalling $10,007,947.

The final phase of the Lazzaro plan was the hiring of Joe Hoffman. To Lazzaro, Hoffman seemed like the perfect choice for the job: a tough-minded administrator with a proven history of balancing budgets.

Hoffman had spent most of his life as a cop, rising up through the ranks from patrolling a beat in Brooklyn to serving as number two under New York Police Commissioner Robert J. McGuire.

His star had risen during the post-Serpico era, when the New York City Police Department was trying desperately to clean up a badly tarnished image. Hoffman played an important role...
in the cleanup, levying fines against corrupt officers in Harlem and playing the point man in a city-wide PR campaign to improve the police force's image.

Hoffman's chief qualification for the health commissioner's job when Koch tapped him for the post was a six-month stint he'd served running the city's emergency medical services, the bureau that coordinated the emergency ambulance teams that worked with police to answer emergency calls.

"They were looking for someone with a bit of a military touch," he says, "and I guess they thought I was the man to provide that."

Hoffman's not kidding about this "military touch" stuff. One of his first steps as director was to reorganize the ambulance corps as a paramilitary organization, assigning ranks to the staff—sergeant, lieutenant and so on—to tighten up slack discipline.

He also instituted an innovative policy for on-call ambulances, assigning ambulance crews to cover beats on the street. Like cops, they were to cruise the boroughs and look for trouble while they waited to answer emergency calls.

It was just this sort of no-nonsense, gungho management style that Koch was looking for to clean up the city's troubled hospital system.

Like most of the rest of New York City in the late 1970s, the city's hospital system was a notorious fiscal disaster. Yearly deficits were running into the tens of millions, and the city was running out of time and money to deal with the problem.

When Hoffman accepted the commissioner's post, it looked like he had taken on a very nearly impossible job. All three of his predecessors had been forced to resign amid loud recriminations. But they, unlike Hoffman, had all been practicing MDs, lacking the hard-boiled executive savvy needed to run such a huge operation.

"What the hospitals needed," says Hoffman, "was a good solid dose of management."

Hoffman's relationship with the city hospitals was an uneasy one from the start. He had accepted an uncomfortable mandate—to pare down an already strained medical system—and his efforts met with stern resistance from the medical community.

On January 17, 1979, months before Hoffman announced his first round of budget cuts, a group of more than 300 municipal staff doctors staged a 25-hour strike to protest the looming prospect of closings and cutbacks. After the doctors returned to work, Hoffman showed them he meant business. He levied fines against them totaling $24,000.

His original notion for cutting the city's health costs—closing down four city hospitals—never made it much past the planning stage. Only one was actually closed, and it was so run-down it would most likely have been closed any way. The rest of Hoffman's cutbacks fell well short of projections.

Nonetheless, Hoffman did a fair job with the resources he had, tidying up the administration and decentralizing the system, trying to encourage greater accountability among the individual hospitals. He made major improvements in the all-but-nonexistent collection procedures, billing Medicare and Blue Cross for procedures that had previously been performed free of charge.

By most accounts, Hoffman's tenure was a successful one. But his lack of medical expertise prompted Koch to propose bringing in a co-administrator, whose duties would involve overseeing the more specifically clinical problems within the system.

When Hoffman learned that his administrative powers might be compromised, he decided to step down from the post. "Koch was undoubtedly right to be thinking in those terms, and I have no hard feelings towards him," he says.
“But my philosophy is that to run a good operation you need one single manager.”

When Hoffman arrived at Bay State, after stints as president at St. Vincent’s hospital in New York City and as a vice president with W.R. Grace in Waltham, he found himself in charge of another troubled organization.

Compared to the vast mess he’d handled in New York, Hoffman thought the problems at Bay State looked practically benign. “By the time I got here,” he says, “I could already see the smoke clearing.”

In the 18 months since Hoffman has come aboard, the turnaround seems to have gone smoothly. “The Lazzaro group had turned the ship around, so to speak,” says Hoffman. “It’s been my job to make sure the whole thing stayed on course.”

He is doing just that. Claims are getting paid on time; the administrative staff is jelling into a stable unit; the troubled computer system is finally getting an overhaul; and Bay State’s net income is comfortably in the black.

But the whisperings in the city’s gossipy health-care community have yet to die down. The apparent speed and ease with which the company has turned itself around has left many industry insiders scratching their heads, wondering: What gives?

“Everything looks so clean and neat on paper,” says one industry observer. “But you can’t help but wonder if there isn’t something fishy going on here.”

Somehow Bay State has managed, in less than three years, to turn around a multimillion-dollar deficit and parlay it into healthy reserves of more than $29 million, according to the latest quarterly figures. And they did it without significantly raising their premiums.

Bay State’s premiums, while still slightly higher than those of rival HMOs, have increased at a rate much slower than the industry average—about one-third slower, according to figures from the Division of Insurance.

The key to Bay State’s budget balancing has not been increased revenues but a tight control of expenses. This January, Bay State formally instituted its new billing rules, shifting more of the administrative footwork onto the member hospitals.

Although Bay State says the new regulations are designed to reduce the overall load of paperwork, the hospitals say that Bay State is actually trying to foist its administrative responsibilities onto the hospitals. “The cost of doing business with Bay State is enormous,” says a senior administrator at Boston’s Beth Israel Hospital. “Our relationship with them is by far the most adversarial of all our HMO contracts. They refuse to treat us as partners in health care. They insist on treating us like bad-actors.”

Other area hospitals have similar complaints. Bay State flatly rejected some 400 claims from Somerville Hospital, saying they had been “improperly” filed—despite Somerville’s assertion that most of the claims had been filed in accordance with the old regulations, which they say had been in effect when the claims were originally filed.

“Basically,” says a Somerville administrator, “they made us eat it.”

Other complaints come from smaller, private health-care providers. Cataldo Ambulance Service, of Somerville, recently filed a litany of complaints with the state Division of Insurance, charging in no uncertain terms that Bay State had cheated them out of more than $50,000. Cataldo charged that its claims “continue to be rejected for reasons that we can feel only be excuses for non-payment.” Those reasons included seemingly arbitrary fee reductions and rejection of already authorized claims.

“We are being forced to subsidize you,” read the complaint. “This must stop!”

The Division of Insurance says Bay State generates more than its share of complaints. “There’s been a real rash of complaints against Bay State in recent months,” says Nancy Turnbull, deputy commissioner for health policy at the division. “They’ve always drawn more complaints than the other HMOs; in large part, that’s a function of their size. But lately they’ve been way ahead of the pack.”

Bay State’s primary mechanism for rejecting claims is its “peer-review” committee, a board composed of member doctors who monitor other doctors’ decisions and make recommendations for claim rejections or fee reductions.

Bay State insists on referring all questionable cases to its own panel, even though most of the larger hospitals have their own in-house review boards to monitor utilization time—boards whose findings are routinely accepted by most of the other Massachusetts HMOs. Although Bay State’s panel is composed of its own member doctors, the panel has a clear-cut mandate to keep a sharp eye on the bottom line.
Bay State's panel almost never sees patients personally, but the company keeps its own salaried registered nurses on staff at most of the larger hospitals. The nurses' job is to monitor Bay State patients in the hospitals and file reports to the review board.

Many doctors take umbrage at the implication that they should be considered less qualified to judge the condition of their own patients than a nurse filing reports to a distant panel of doctors.

said a surgeon at one of the major teaching hospitals, "Who are these people to make this kind of presumption? To tell me they can better judge the condition of my patient from a distance—a patient they have never even laid eyes on—when I see that patient every day? Frankly, resent that."

It is over the issue of peer review that Bay State and its doctors most often lock horns. Of course, doctors don't like corporate executives looking over their shoulders. But, as Bay State's history has clearly shown, the doctors are capable of spending the company out of business if somebody isn't carping to them about cost control.

Without its stern review policies, the company would likely have no choice but to raise its premiums—and seriously compromise its competitive market edge. Where to draw the line?

It's a tricky question, one with wider implications for the HMO industry.

The doctors and hospitals have easy access to the moral high ground. They're the ones out there saving lives. But they also have their own bottom lines to think about; Bay State isn't the only one thinking profits, after all.

Hoffman knows that. He also knows that Bay State's future will depend on exchanging mutual concessions with the providers whose services are Bay State's stock-in-trade. "In this business," he says, "everyone has to make compromises. That's just the way it is."

Hoffman is right, of course. There will have to be compromises. The question is: Who's going to make them? In its early years, Bay State bent to its doctors' will—and nearly went broke. Now it's back in the black, thanks to Lazzaro's cost-slashing turnaround, and Hoffman is determined to keep it there.

But Hoffman knows that keeping Bay State running smoothly internally is only half the battle. The company's relationship with the outside world suffered terribly through the lean years. Competitors talked up the company's problems with corporate accounts. Bay State denied the reports, but real information was hard to come by. Bad news was bottled up, and when it got out, its career was fired. In the last two years, Bay State has had five public-affairs directors.

Hoffman has begun to dip a tentative toe into the larger eddies swirling around health policy in Massachusetts. He has testified before legislative committees calling for an end to Blue Cross's special place in the health-care system. Two months ago, he stood before a gathering of the Massachusetts Municipal Association and proposed an innovative approach to pooling health-insurance risks among cities and towns.

The concept was sound, but the presentation was lackluster. Hoffman read from the script like—well, like a precinct captain reciting the morning roll call. Shackled to his speech, Hoffman generated little spark in a room filled with municipal officials desperate for help with their soaring health-care costs.

After a decade of near-constant changes, Bay State craves the kind of stability and credibility Hoffman delivers. But in the meantime, while Bay State has been preoccupied with steadying its own ship, the waters around it have changed. The sharks are in the water; the competition is closing in. For Joe Hoffman, it is South Brooklyn once again.