

Academic Medical Centers at Risk: How to Survive Medicare and Medicaid Value-Based Health Care

written by Theresa Hush | April 7, 2015



Academic Medical Centers

(AMCs) provide care to the most complicated patients and have surmounted some of the worst clinical challenges of all time. Yet the biggest issue to threaten survival of AMCs might well be Medicare and Medicaid Value-Based Purchasing.

While AMCs incorporate the training of new physicians in both community and highly specialized care, the clinical complexity of their patient population is higher than other institutions. At the same time, AMCs are the most likely medical centers to offer trauma and burn care, new medical technology and clinical research. But with typically high volumes of Medicare and Medicaid patients, AMCs are prime targets for penalties under Pay for Performance.

Why AMCS Have Higher Cost Profiles

AMCs will generally have a higher cost profile than non-academic centers. A few of the factors that drive these costs:

Being the first line of defense for major health issues. This can cost more, but reimburse less (or not at all). AMCs across the country developed policies and procedures for caring

with patients with Ebola, and while most never saw an Ebola case, they had to prepare in the event that they would. The same applies to other types of care. Level 1 Trauma Centers and burn centers do not provide the profit margins that an imaging center or surgery center might, but the AMC needs access to these capabilities, and at a moment's notice.

Conducting clinical research. This drives higher cost patients and providers to the institution, contributing both to prestige and revenues—and expenses.

Employment of large numbers of top quality physicians, many in sub-specialties. AMCs are in the subspecialty business to provide depth of care, research and training.

Employment models have become the predominant model of hospital-physician contracting in recent years, driven by competition and stronger needs of alignment and care coordination. Simply put, top quality sub-specialists cost more.

The need to provide a variety of clinical areas and settings for physician training, including those that do not generate a great deal of revenue. While many private institutions have discontinued certain types of services due to their inability to be financially sustainable (e.g., inpatient psychiatry), this is not always an option at an AMC. The services need to be available for the community and for resident physicians to receive necessary training.

The cost of physician education, not fully covered by reimbursements or educational funding. This includes direct costs of paying residents, administrators and the support of the AMC enterprise. But there is also the loss of revenue for supervising physicians and those who are training the new class, who are not seeing additional patients. Even before duty hours were reigned in, this was an issue; the limitation simply highlights the issue.

AMCs have been able to dodge the bullet until now for several reasons. Some AMC care has a higher revenue-to-cost ratio than other providers. Other revenue may come from government subsidies that target physician education or research. In addition, private research is often funded by grants. Finally, philanthropy can account for tens of millions of dollars per year, driven by alumni and grateful patients and families who believe that their contributions are helping their communities. Medicare and Medicaid Value-Based Health Care threatens all of these financial pillars—even contributions, since new and more frequent public reporting of quality has the potential to create perceived issues if the AMC doesn't rank as well as competitors for the reasons cited above.

How Academic Medical Centers Can Do Better Under P4P

AMCs have a history of struggling with complexity, and winning. Now is the time to gather forces and deal with what lies ahead. From the easiest to the more complicated tasks, here's what it will take:

Implement smart PQRS Reporting and Value-Based Payment Modifier Optimization. Of the AMCs who did report PQRS in 2013 (several did not report), many used one of two methods: Medicare's web-based Group Reporting method on a sample of patients, or EMR-Direct reporting. Both of these may have accomplished PQRS reporting, but did not address performance under the Value-Based Payment Modifier. As efforts have moved away from simple reporting and toward comparative performance, an essential part of every AMC's quality program should be devoted to efforts aimed at "proving better" performance against national and CMS means. AMCs have the opportunity to avoid penalties due to poor VBPM quality tiering calculations—but only if they structure PQRS reporting to do it, and build in processes to improve their risks under the VBPM through a Registry-supported module.

Pay attention to the public reporting of quality results. Medicare is reporting PQRS results publicly on the Physician Compare website, including results (both reporting and performance) on specific measures, and how those results compare to others. With these results being available to anyone (patients, potential patients, alumni, the media), AMCs have far more at stake than the payment adjustments within the program itself. Public reporting of poor P4P results can very likely cause deflated donations and decreased patient volume. All the more reason that AMCs must be proactive in order to succeed in this landscape.

Prepare for risk with Population Health technology and projects. Medicare has declared that most of its reimbursements will come through Accountable Care Organizations (ACOs) in the years ahead, and Medicaid programs across the country are already in a similar transition. Population Health technology, projects and processes will be needed for AMCs to improve the outcomes and lower the costs of their significantly sicker—and often poorer—populations.

Put population health outcomes on the research agenda. Most resources in AMCs are being directed at drugs and various other clinical trials. Who is looking at the outcomes of the AMC itself? In conjunction with efforts to improve quality and reduce costs, actual research about what is really working to produce the best outcomes—and where research needs to be dedicated—seems like a natural for an AMC. A well-done Registry can enhance research activities.

Track care delivered by residents. A lot of care decisions are generated by resident physicians, and these decisions can affect the bottom line of the AMC. Tracking care delivered by residents may be one of the most important new avenues to improve the value of the AMC while lowering the number of unnecessary ER-based admissions, tests and problematic outcomes. The AMC should evaluate the CLER standards and begin a quality process to incorporate residents and fellows into a Value-Based Health Care track to evaluate outcomes and decisions.

Evaluate participation in referral networks, health systems and ACOs. Some academic centers have invested in primary care, but usually not enough to be able to support their

vast networks of specialists. With the plethora of new networks that may attempt to compete with AMCs in both patient care and clinical research, it is important for an AMC to evaluate its options for expanding its mission and contributing to the advancement of the science of improvement.

Balancing academic and clinical care goals is an achievable task. Academic Medical Centers can avoid penalties and continue to succeed in the move quantity to quality, but it will take commitment, focused effort and several years to complete. The time to start the transition is now.

[Download your free copy of the ICLOPS Insider's Guide to PQRS 2015 Reporting: How to Succeed in the Value-Based Health Care Environment.](#)

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Image Credit: Scanning electron micrograph of Ebola virus budding from the surface of a Vero cell (African green monkey kidney epithelial cell line). [NIAID](#), 8-12-14.