Can Academic Medical Centers Be a Force for Health Care Reform?

written by Theresa Hush | September 14, 2017

Can Academic Medical Centers (AMCs) survive Value-Based Health Care and its metamorphosis

to financial risk? That's the question many industry watchers have been asking for several years, as margins have slimmed and some university-based programs have sold off their facilities and physician groups to private interests.

But a number of economic and policy impacts are generating greater urgency regarding the status of AMCs, threatening their ability to continue their historical three-part mission of teaching, research and specialized patient care. While AMCs have been targeted as "high rollers" by those seeking to control health care costs, we should be very concerned about their future status. Why? Because the failure of many AMCs would be a hit for the whole health care system.

Solutions to creating better Value in health care must also include how to evaluate and reimburse the role of AMCs in their specialized endeavors. AMCs themselves also need to learn how to adapt to the economic environment while fulfilling their roles. They must become a *force* for health care reform, not passive participants, if they want to succeed as leaders in their geographic networks. Here's a plan to achieve that:

AMCs Are an Economic Powerhouse—And an Economic Hot Spot

Recognition of the role that AMCs play is critical to defining their future role. AMCs are economic powerhouses in their communities. They provide a major source of employment for both clinical and administrative staff. They are also a significant player in the medical care system, often the largest provider of charity care as well as specialty services. They are unique because, while their services often overlap with other specialty networks, they often serve patients at higher risk or with fewer financial resources.

AMCs include both hospitals with and without medical schools, each with a separate set of issues. The large institutions with medical schools are research- and resident-heavy, with a patient mission driven by specialty care. Once at the top tier of the health system with heavy tertiary care capabilities, university-centered AMCs have scrambled for a number of years to recover their "cash cow" market status; their higher cost and lower margins are now a liability. Some hospitals have been sold to health systems or spun off independently, and others have developed alliances within their regions to maintain survival.

AMCs have a special role in the health care system:

> They form the infrastructure for educating and training physicians. This is significant in light of the consensus that a future physician shortage is looming.

> AMCs are the primary conduits for clinical trials and medical research needed to advance medicine and determine cost-effective choices of treatment. They are large recipients of pharmaceutical firm money as well as federal funds for research.
> As tertiary centers, AMCs deliver specialized medicine that cannot be easily transferred into mainstream healthcare institutions—treating rare and orphan conditions, offering highly specialized procedures and treatments, and providing higher end technology. These are also expensive and long-term pursuits, not easily transferred to organizations without large resources or academic structure.

Each of these aspects of AMCs is under attack either by health care reform efforts or directions in modern health care and technology. In patient care, AMCs are perceived by insurers as high cost generators. They generally attract poorer and sicker patients and offer services that others do not; as a result, superficial comparative data does not always present a positive picture of AMC outcomes in relation to their costs. There are some reasons why these comparisons are unfair. Regardless of these misconceptions, however, large groups such as AMC-employed physicians will remain vulnerable to payers until they make progress on cost reduction.

AMC patient care is also often characterized by fragmented specialty services, lack of coordination among physicians (even if employed by the same entity), and the necessity of the patient to act as his or her own care coordinator. Patients often must fight the "system"—struggling to get access to their records and images, arranging their own care, scheduling their services, and fighting for reimbursement when payers have segmented the AMC into areas that are covered benefits, or uncovered because of costs. These patients must often wade through the resident and attending caste system before reaching the right attending for answers or to make preferences understood. The bureaucracy of AMCs is often unkind to patients.

In addition, AMC research is under increasing public and professional scrutiny for its failure to focus on well-designed studies of treatment efficacy. There are also frequent allegations of collusion in AMC-run clinical trials funded by Pharma and device manufacturers, as well as conflict of interest in papers that promote publication over content. But an even more significant challenge to AMC research is the growing potential for practice-based research as data becomes more available for evaluation of outcomes and efficacy, as well as the development of stand-alone research operations that can facilitate precision medicine fueled by greater genetic information. Unless they embrace such totally new directions in data-facilitated research, AMCs risk irrelevance.

Finally, the AMC education and training mission has caused concern by its overemphasis on hospital-based training rather than ambulatory, and specialty care over primary. While these

are appropriately the domain of professional Boards, because the AMCs realize the value of residents through higher admission volume and fees, the AMC bears the brunt of criticism.

Value-Based Health Care Will Have Impact on AMC Viability

Value-Based Health Care has arrived for both Medicare and Medicaid—heavy contributors to AMC revenue. As a result, the health of AMCs—especially those with medical schools and university hospitals—is under question. With MACRA, the relatively high cost structure of AMCs will make it difficult for them to achieve the best comparative scores among Medicare providers, triggering penalties that could reduce Medicare revenues as MACRA is fully implemented. Similar efforts among commercial insurers to restrict provider networks to lower cost physicians and institutions (the majority of Exchange policies include narrow networks) further isolate academic institutions so that patients can't use them without paying a higher price.

Affordable Care Act repeal, if it happens, will cut sharply into AMC patient care revenues in addition to support for teaching and research. On top of these pressures are targeted budget reductions, including federally funded research dollars, funds that researchers at university-based AMCs use to subsidize their academic mission.

Past AMC Strategies Fall Short of Needs

AMCs have deployed several strategies over the past few years to unburden themselves financially:

> Spinning off university foundations and being sold, such as University of Arizona to Banner Health, and Vanderbilt University. This moves financial responsibility without necessarily changing the underlying economics.
> Participating in broader clinical integration networks for the purposes of quality reporting, cost reduction and better contracting.
> Developing ACOs, most of which have not generated savings.
> Focusing on the infrastructure rather than governance through purchase of primary care practices, or employing such physicians to build a large patient base.

None of the strategies is sufficient for meeting Value-Based Health Care or preparing for financial risk. Instead of a focusing on concrete performance improvement initiatives, they simply move the problem down the road. Over the long run, the costs associated with AMCs are either distributed across a larger population or absorbed by other providers.

AMCs Can Lead Real Health Care Reform—But Culture Must Change First

AMCs have all the assets needed for regaining a leadership role in creating Value in health care. But it will take work. Here are some opportunities:

Create Physician Leadership Throughout the Organization for Engaging in AMC Transformation. In hospital-heavy AMCs where rank and file physicians believe they have become "cogs" in the machine, there must be a turnaround that engages physicians in the future of the organization. That engagement can only happen if clinicians play the dominant role in clinical performance and development of coordinated care programs. Physicians across the organization should be cultivated as leaders and involved in the development of solutions to AMC issues. They will make time for it, if they are inspired and believe that they will be able to contribute.

Ask the Patients and Consumers. The time is past for simple surveys and rote responses to patients and consumers. The biggest transition going on in health care is toward consumer cost sharing and patient decision-making. If AMCs are to succeed financially, patients as well as physicians will make that happen.

Lead the Community in Value-Based Health Care. AMCs should adopt programs to organize VBHC in their communities and help to define appropriate measures of performance and improvement models. By leading the discussion, AMCs can open the conversation with payers and referring groups about issues needing resolution, and create solutions. Lacking these initiatives, AMCs will find themselves on the fringe of regional discussions and be cast as the high cost/specialty center.

AMCs can become ACOs or develop them, but they should do so only if they have the ingredients to make it work, especially an adequate primary care physician base. Without that, the only value to being an ACO is access to Medicare claims data to see how badly they are leaking patients to other providers. With a primary care base, however, AMCs have all it takes—with physician engagement—to create real continuity of care and care teams that work to resolve patient issues.

Adopt Cost Measures as Well as Quality. AMCs should face the charge of high cost head-on by measuring cost through a variety of tools and across all points of care. One good strategy is to work with a QCDR that can access AMC—and other providers'—clinical and claims data to create metrics and risk-adjust patients. The objective is to investigate the elements that are going into the higher cost of care per patient by condition or procedure, arranged by risk. But this is only a beginning to determine whether there is overuse of services, and this is why a QCDR with cost measurement expertise can be valuable.

AMCs must adopt defensive cost strategies as smaller and more nimble providers offer fringe services in the market. For example, the establishment of freestanding MRI and other radiology services in the community will provide lower cost options to the higher costs that are charged for similar services at AMCs, because of higher overhead.

Use Performance Measurement to Look at Data, but Focus on Performance Improvement. With the overemphasis on reporting quality to Medicare and health plans, there has been an overemphasis on measure results as "scores" of quality. This is a real misuse of data, especially for outcomes that are reported once per year. Instead, AMCs should work with QCDRs to evaluate outcomes over time and determine how to create pilot initiatives that engage physicians and patients in shared responsibility for better long-term outcomes.

Be the First to Create Specialty-based Episodic Treatment Packages, with Pricing. With their concentration of specialties and other resources, AMCs can realistically develop episodic care packages for building referral business. The coordination of care and communication under these packages is key, as well as the pricing. Episodic packages will alleviate the concern among primary care physicians and others about sticker shock. Additionally, they will facilitate the process of developing interdisciplinary care teams for complex cases, establishment of appropriate quality and outcome metrics, and fair pricing.

Align Teaching Mission with Value-Based Health Care. AMCs have a role in the teaching of shared decision-making processes, care plans that are organized with the patient and caregivers, and an ambulatory-focused approach. Clinicians in training must be made more aware of the costs of health care services.

Pursue Practice-Oriented Research. AMCs are notoriously poor at measuring quality and performance in their own patient populations, and only partly from lack of data from other providers. To remain relevant amidst the tide of new data and new organizations that analyze such data—including Artificial Intelligence ventures—AMCs will need to reconceive their mission to be more targeted on cost and efficacy and more focused on patient care. It is likely that National of Institutes of Health funding will diminish over time and clinical trials will move to different models to test efficacy as well. AMCs that want to continue research must do so because it brings value to their physician researchers and patients.

AMCs can navigate and even lead the way for their communities on Value-Based Health Care. But the deeply ingrained, history-steeped culture in academic medicine must first shift. Currently the three missions of AMCs are in conflict with each other, as well as with external forces. The survival of AMCs will depend on the successful navigation of the unique expertise of AMC physicians as well as the significance of their role *for their communities and their patients*. Like every other part of health care, AMCs are still rooted in their locale. Lead rather than follow, or risk irrelevance.

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