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Academic Health Focus

Population Health and the AMC Chase: Five Hurdles to Value-Based Care

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Academic medical centers (AMCs), for the large part, are late to the population health game and have been playing catch-up. Though uniquely innovative and focused on both clinical care and research, AMCs are challenged by systemic obstacles that make transformations difficult, as change requires new levels of collaboration across the entire organization. Simply put, changing a delivery system while successfully sustaining operations within some of the most complex institutions in the country is a multifaceted transition. What could possibly go wrong?

Due to the rising costs approaching 20 percent of gross domestic product (GDP), physicians and hospitals are facing significant pressure to manage the total cost of care more effectively and efficiently. More and more, the financial risk and burden for the cost of care are transferred to providers. Some health systems are playing a zero-sum game, chasing margins of an outmoded fee-for-service model, while other systems are working towards improving the value of the care delivered.

Transitioning an AMC's healthcare delivery model requires a well-planned and well-paced strategy to simultaneously and synergistically impact the underlying business and clinical models. The pace of change of delivery transformation and risk-bearing must be in "lock step" or the business model will not support the clinical delivery model. Their difficulties in value-based care are borne from necessity and must be understood in order to navigate a path forward. This article discusses five major hurdles AMCs face along the value-based transformation path, including key action items for governing boards to consider when identifying solutions and trying to ensure a seamless transition.

Key Board Takeaways

- Have a well-planned and well-paced strategy when transitioning the AMC's healthcare delivery model. This strategy should simultaneously and synergistically impact the underlying business and clinical models.
- To deal with the continued pressures on the healthcare dollar, AMCs should develop a long-term strategy to transition to value-based care. AMCs are actually in the best position to perform well in value-based care because they often have the capital to invest in required infrastructure, one of the strongest provider–payer relationships in their communities, the best analytics horsepower, and the brightest brain-trusts in the world.
- Remember that collaboration is key. In reaction to the COVID-19 pandemic, the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) recently released guidance that encourages hospitals, health systems, and medical groups to collaborate with each other. Responding to the COVID-19 pandemic successfully will likely require such procompetitive collaborations among healthcare providers. AMCs often struggle with "silo-syndrome," but success in value-based care within a complex system requires deep involvement of senior leadership at the most senior levels and alignment of partner organizations such as IPAs or a CIN.

1. The Inverted Pyramid and Specialists' Puzzle

Balancing financial sustainability for specialists, while managing performance and utilization under various risk models for specific populations, is the first strategic hurdle to maneuver. AMCs are the home to a preponderance of medical specialists at the forefront of clinical research and delivery. This, however, is not a natural or automatic fit with the basic tenets of value-based care, which is almost by definition heavily dependent on primary care

strength and attribution models. Medicare's reimbursement model through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) uses percent-revenues under advanced payment models. This provides a disadvantage on AMCs that are often the downstream provider for many otherwise non-attributed patients requiring expensive tertiary and quaternary care. Some next steps for consideration include:

- Developing a system-wide Merit-Based Incentive Payment System (MIPS) quality reporting infrastructure to alleviate burdens on each department/specialty.
- Splitting taxpayer identification numbers (TINs) so that primary care and specialties are separate and can take most advantage of MACRA available.

2. The Contracting Paradox

The vast majority of hospitals' operating margins are through fee-for-service and other volume incentives. In other words, "heads in beds" still matters. Value-based care can be seen as a means to diversify revenue to positively contribute to the system's bottom line. High value can drive good business in both volume and value. Nonetheless, this is a difficult calculus since changes to care delivery can impact metrics, such as inpatient admission rates, as populations served begin to grow. The ability to forecast and model how risk-based scenarios play through system-level economics adds to the complex calculus. Here are a few approaches to consider:

- Learn the "calculus" by investing in contracting and financial modeling tools. Value-based care is a different business paradigm and will not be going away. Limiting your own abilities in understanding this shift only favors the payers.
- Take risk in areas that you can deliver upon and understand the financial fundamentals and grow from there. This, however, will be unique to each system and geography.

3. Right-Sizing

The traditional AMC of multiple behemoth centers and hospitals with a heavy focus on inpatient services for a given geography is becoming anachronistic. When specialty services are not concentrated, patients are ill-served by programs that do not perform enough volume to provide the highest-quality care. Repetition very much matters in team-based approaches to care. Otherwise, variations in care multiply and the system is further burdened by duplicative fixed costs. Newer models include smaller, modern acute care facilities with full-service emergency departments, comprehensive behavioral health services, and otherwise a virtual mostly ambulatory hospital without walls that integrates seamlessly into the community and home and provides the most effective and convenient care. Other key considerations include:

- COVID-19 crisis transforming facilities into alternate care settings
- Flexibility of space
- Broader collaborations

4. Primary Care Alignment

Value-based models rely on attribution methodologies. You must define the population as a given denominator in order to measure and improve quality or efficiency of care delivered. Most methods ascribe to primary care attribution models as "home base," which has driven a fierce re-interest in primary care practices and physicians. Lest we forget that the history between most hospital systems and community physicians is tenuous at best, and the new reimbursement methods promote new interest in partnership and alignment strategies to achieve the promise of new value creation. For employed, independent, IPA-affiliated physicians, and/or a clinically integrated network (CIN), some of the panoply of strategic opportunities to better align with primary care physicians include contracting efforts, compensation reform, innovative incentive and benefit design, wraparound services, IT and analytics, and more. Next steps include:

- Compensating primary care physicians appropriately and *differently*.
- Setting expectations to understand that true value-based care delivery includes temporarily remaining reliant on a fee-for-service chassis, with marginal upside for new value.

5. Leadership and Partnership

AMCs often struggle with "silo-syndrome" or even "fiefdom management." Success in value-based care within a complex system requires deep involvement of leadership at the most senior levels. Population health requires harmonization across every aspect and department of a system and often stretches the normative boundaries of collaboration. Venn diagrams begin to actually meld together from administrative services of legal, finance, compliance, contracting, and IT; to MSO-like services of care management and wraparound

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services, new claims, and payment methods; through clinical and behavioral health delivery services and practice transformation. Some to dos for AMCs include:

- Systems must really improve coordination as that efficiency is being rapidly tested through payment reform and financial risk transfer.
- System politics must be maneuvered across varying foretold priorities.
- Leadership across system and academic/clinical departments must be aligned and motivated for joint success in value-based care.

Is There Any Good News?

In many ways, AMCs are actually in the best position to perform well in value-based care. They have the capital to invest in required infrastructure, one of the strongest provider–payer relationships in their communities partnering for innovative delivery offerings, the best analytics horsepower, and the brightest brain-trusts in the world. Harnessing these capabilities for population health can be of incredible value. However, it is easy to feel paralyzed when looking at the many pivots required and new core competencies needed on top of the hurdles inherent in their current structures. Cohesive and comprehensive strategies forward are most important.

The Governance Institute thanks Andrew Snyder, M.D., Principal and Chief Medical Officer, and Sarin Khachatourians, M.H.A., Senior Consultant, COPE Health Solutions, for contributing this article. For more information on how AMCs can successfully pursue population health management, please contact Dr. Snyder at asnyder@copehealthsolutions.com or (401) 225-9417.