The Affordable Care Act and Academic Medicine: Turbulent Times

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AMCs are Major Providers of US Health Care

- AAMC-member teaching hospitals represent 6% of all hospitals and provide 23% of all hospital care
- Their work represents:
  - 21% of all Medicare inpatient days
  - 28% of all Medicaid inpatient days
  - 40% of all hospital charity care
- They provide:
  - 79% of all burn center beds
  - 40% of neonatal intensive care beds
  - 83% of all ACS-verified Level 1 regional trauma centers
My hospital, the Brigham and Women’s Hospital, received thirty-one victims, twenty-eight of them with significant injuries. Seven arrived nearly at once, starting at 3:08 P.M. All required emergency surgery. The first to go to surgery—a patient in shock, hemorrhaging profusely, with inadequate breathing and a near-completely severed leg—was resuscitated and on an operating table by 3:25 P.M., just thirty-five minutes after the blast. The rest followed, one after the other, spaced by just minutes. Twelve patients in all would undergo surgery—mostly vascular and orthopedic procedures—before the evening was done. This kind of orchestration happened all across the city. Massachusetts General Hospital also received thirty-one victims—at least four of whom required amputations. Boston Medical Center received twenty-three victims. Beth Israel Deaconess Medical Center handled twenty-one. Boston Children’s Hospital took in seven children, ages two to twelve.

Why Boston’s Hospitals Were Ready

The Current Threats:
Most AMCs continue to produce healthy operating margins….however, we are beginning to see “cracks” in our financial stability….more public and private teaching hospitals are posting negative operating margins
Care is moving to an outpatient setting. Hospital admissions have been decreasing nationally for the past 5 years
Facing close to an 8% decrease in total Medicare payments
Loss of 50% of DSH with the implementation of the ACA
Loss of HOPD support
Potential decrease in commercial business which moves into the exchange at lower rate.

The Challenge:
Can we recover like we did in the 90’s?

Hospital Total Margins 1996 - 2010

[Diagram showing hospital total margins from 1996 to 2010 for Major Teaching, Other Teaching, and Non-Teaching hospitals.]

Note: Major teaching hospitals are defined by a ratio of interns and residents to beds of 0.25 or greater, while other teaching hospitals have a ratio of less than 0.25. Total margins include all patient care services funded by all payers, plus non-patient revenue. Analysis excludes critical access hospitals.

How Are We Positioned?
Funds flow for Education/Research/Clinical Care

All Fully Accredited Medical Schools Have Witnessed Exponential Growth Fueled by Medical Service Income

The Problem:
Funds flow from the clinical enterprise is on average 8.7% of NPS revenue and growing. This is not sustainable.

FY10 Funds Flow by Purpose (average of all participants)

Source: LCME 1-A Annual Financial Questionnaire (AFQ), 2011
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Flow of Funds in AMCs...

Current Reality about AMC Missions

- **Education**
  - UME costs (complex) higher than tuition
  - Medicare Direct GME $3B (out of $13B)

- **Clinical Care**
  - Average COTH Medicare margin about—3%
  - Medicaid losses higher
  - COTH provides $8 billion charity care/yr
  - No explicit payments for standby care
  - Many clinical service lines lose money

- **Research**
  - NIH, other grants don’t pay full costs

Medicare Covers 21% of Direct Teaching Costs (DGME)

- There are ~110,000 trainees.
- The average DGME cost per trainee was $143,000.
- Medicare based its reimbursement on a $101,000 PRA.
What about Graduate Medical Education
Deficit reduction proposals to reduce Medicare GME support by as much as $60 billion over 10 years, including a 60 percent reduction in Indirect Medical Education (IME) payments, would threaten critical services and decrease physician training at a time when there should be increased support for doctor training.

• In just 14 months, as many as 32 million additional Americans will enter the health care system with health insurance, just as the United States faces a shortage of physicians.

• For the next 19 years, 10,000 people a day will turn 65 creating a significant increase in demand for health care across many specialties.

A Growing, Aging Population Matters
Physician Utilization per 100,000 people by Age

Caps on GME & Workforce
Knowns
• Increased insurance coverage
• Growing population
• Aging population with higher per capita needs
• Expected decline in physicians per capita
• Medical advances increasing utilization over course of lifespan

Demand vs. utilization vs. need & current supply?
Assumptions about current vs. future system?
Change the Lens on GME

Multiple calls for more accountability for public GME dollars. Outcome measures that can be used to demonstrate the effectiveness of the GME training process to produce a physician workforce to meet society's needs

Dominant is the call by MedPac to place 50% of IME at risk based on GME outcomes

Calls for accountability in public programs are not unique to GME: other forms of education (K-12), HIT, payment reform, etc.

Workforce Development and Influence are Clearly Multifactorial

- Personal background and characteristics
- Medical school experiences
- Medical school debt
- Specialty choice and practice location
- Health system priorities and perceived market conditions
- Professional interests
- Residency experiences
The social reality....
All of this change is really in pursuit of creating a sustainable health system
Medical education and research can be drivers of excellence
Relentless focus on costs and quality…strip out anything from your processes that does not deliver value to patient
This is a marathon …not a sprint. The dangers of speed are diminished access for the vulnerable, risk of undermining our education and research infrastructure
Patients need to be partners…not passive recipients

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Why Are AMCs Worried?
We are seeing narrow networks develop in Mass exchange and in commercial payers
Some require PCMHs
Some tier within plans…primary care physician groups and Hospitals
Gic required two plans to offer narrow network or a 20% premium decrease that excludes all of Partners, Lahey Clinic, and Beth Israel
Tier 1 $150 inpt copay/ no deductible
Tier 2 $150 inpt copay / $500 deductible
Tier 3 $1000 inpt copay/ $2000 deductible
Disproportionate Share (DSH)
Teaching Hospitals have long provided uncompensated care to low-income and underserved individuals. To help offset the cost of this care, hospitals receive funds through the Medicaid and Medicare DSH programs. On the assumption that the number of uninsured and underinsured people will fall precipitously via creation of state exchanges and expansion of Medicaid, beginning in 2014, the ACA decreases the amount of DSH payments under both programs. In states that do not expand Medicaid to all people up to 138% of the federal poverty line, the need for uncompensated care may remain relatively stable while the amount of DSH funds that were previously used to subsidize some of that care will fall substantially.

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NIH Funding – FYs 2000-2014

Labor-HHS Budget Authority only
Sources: NIH Budget Office, House and Senate Appropriations Committees
What research brings:
Ann Bonham PhD post on Wing of Zock

Medical research has vastly improved the health of average Americans and has bolstered both the length and quality of their lives.

The survival rate for children with the most common childhood leukemia is now 90 percent. Five-year breast cancer survival rate has increased from 75 percent in the mid 1970s to 90 percent in 2011.

Chronic disability among American seniors has dropped nearly 30 percent since 1982.

Few would deny the social and economic benefits of medical advances made possible through research.

Research
Increasing call for accountability

Nurturing and sustaining public support for the full spectrum of medical research from bench to bedside to community, and for ensuring a diverse, robust research pipeline is essential for our future. By taking the lead in demonstrating accountability as well as evaluating and communicating the value of medical research to broad audiences with a suite of academic and non-academic measures, the research community can bolster ongoing public support for funding.

Context: Emerging Vision for AMC’s

“Emergence”, Emphasis on training Emergence of AMCs as leading institutions for clinical delivery

“Islands of Care”

“Clinical Systems”

“Systems of Care”

“Deliver Advanced Care” Ambulatory Centers Advanced Technology EMR’s Successful business models

“Clinical Systems” Personalized Medicine – within a frame of population healthManage the financial and performance risk with population health

1980’s 1990’s 2000’s 2020
Clinical Enterprise Project Goal: Partnership with Manatt

Create a vision of the future Clinical Enterprise at Academic Medical Centers

- Drivers of evolving health care system for AMCs:
  - Movement from fee-for-service payment toward value based payment
  - Need to achieve order of magnitude reductions in cost structures (of clinical and academic enterprises)
  - Need to participate in consolidating markets and not be marginalized; and
  - Need to manage population health

Focus/Outcome: Project should focus on developing a blueprint of best practices/principles for leadership that will help AMCs move to a sustainable model in the future. Report begins with premise that AMCs are distinguished as institutions that support opportunities for translational research, testing innovative models of care, and education. With those foundational commitments, AMCs must learn to decrease cost, increase integration, and right-size in this new era. The generational shift away from hospital based care must be recognized and addressed.

Profiles of Leadership

- Cleveland Clinic
- Emory Healthcare
- Iowa Healthcare
- Montefiore Medical Center

Leadership Dimensions

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<th>Profile Area</th>
<th>Dimensions</th>
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| Strategy and Governance | • Clinical Strategy
  • Scale
  • Leadership Coordination
  • Role of the Chairs and Physician Leadership
  • Education, Research, and Innovation |
| Fiscal Affairs      | • Transparency
  • Compensation & Incentives
  • Access to Capital |
| Network Services Strategy | • Primary Care Network Development
  • Community Physician Engagement/Clinically Integrated Network
  • Mergers/Joint-Ventures/Affiliations |
| Performance Management | • Management of Risk
  • Data Analytics & Measurement
  • Cost Management & Quality of Care |
Themes
1. AMC of the future will be system based
   • These AMC systems require strong and aligned governance, organization, and management systems
   • Growth and complexity of AMC system requires evolution in the roles of Department Chairs, new roles for physician leaders, and evolution of the practice structures
   • Transparency in quality, performance, and financial information at all levels of the organizations central to achieving high achievement
   • Time for Denial on Costs is past & Time for Leadership on Population Health is Now
   • Candid assessment of strengths and weaknesses essential to achieve change
   • These AMC systems require strong and aligned governance, organization, and management systems

Theme 1: AMC of the Future will be System Based
• Consolidation of providers into systems requiring AMC system development. Preparation for future risk assumption requiring breadth and increasing vertical & horizontal integration.
• In developing regional systems, AMCs must manage the brand as they develop strategic partnerships.
• System scale must be sufficient to maintain competitive parity & mission sustainability – multi-billion in size.
• Access to Capital will be a determinant of future system success

Theme 2: AMC Systems require *strong and aligned* governance, organization, and management systems
• AMC Systems aligning clinical services under leadership that is unified strategically or structurally, enhancing clinical coordination and strategic planning, accelerating decision making, and creating accountability for performance with new emphasis on cross-departmental collaboration
• New structures proving effective because of the trust and commitment to collaboration of their leaders. They are having honest conversations about allocation of resources, simplifying decision making, and evolving the role of leaders commensurate with multi-billion dollar organizations.
• System organization models will differ and there are alternative approaches to organizing clinical entities to achieve economic alignment
Theme 3: Growth and complexity of AMC system requires evolution in the roles of Department Chairs, new roles for physician leaders, and evolution of the practice structures

- Emphasis on quality of leadership: selection, succession, training
- Evolutionary change rather than revolutionary. Trends include:
  - Emphasis on teamwork amongst Chairs and with system leadership
  - Delegation of selected functions to group or management
  - Accountability for departmental performance and financial transparency across departments
  - Strengthened role for physician executives, esp. CMO/CMIO/Group Practice management
- FPP leaders are asking the question – “Do we want to be THE physician organization for the health system, developing processes for the addition of clinical faculty and affiliates, or one of many boxes of physicians for the enterprise on an organization chart”. The answer may vary from institution to institution.

Theme 4: Transparency in quality, performance, and financial information at all levels of the organizations central to achieving high achievement

- Impossible to succeed in taking on risk / bundles without true understanding of costs across hospital and practices
- Quality reporting and innovation in demonstrating outcomes over longer time periods will be essential to maintain “premium” AMC brand
- AMCs must be more explicit about value (quality/cost) and how they position themselves in the market. The ability to define quality outcomes to purchasers is as critical if not more critical than simply lowering the cost structure for purchasers.

Theme 5: Time for Denial on Costs is past & Time for Leadership on Population Health is Now

- Persistence in high costs of AMCs primary competitive disadvantage for system success
- Total leadership commitment to lower costs a pre-requisite for taking on population health and risk assumption strategies
- Re-engineering must extend to all missions
- Potential for AMC innovation in total cost management by delivering best results on utilization
- Broad investment in new skills such as LEAN across faculty and staff
**Leadership: From talk to action**

- The primary action item for AMCs is **strategic alignment**. Without this being at the focus of every organizational decision, we will not be able to succeed. **Economic alignment** – balance of sources and uses to build the future system – is a precondition for strategy execution.
- Themes and strategies being pursued by AMC leaders hearken back to 2000
- AMC leaders taking action to create change, demonstrate results, build the systems for the future
- Massive commitment of investment dollars in future infrastructure: physician networks, IT and Informatics, new programs & facilities
- Acceleration of work to create linkages with community affiliates as networks formalize
- Renewed emphasis on strengthening primary care
- Execution – Execution – Execution!

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**Theme 6: Candid assessment of strengths and weaknesses essential to achieve change**

- Changing market and policy dynamics are forcing organizations to assess ability and capacity to succeed as organized systems of care
- AMC System strategy difficult and costly to execute
- Board and Leadership must have a new level of candor about capabilities and evaluate the “cards” the AMC holds – or doesn’t – in its hand. A weak hand requires rapid action, selection of strong partners, and investment in new capabilities

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**Which Cards do you hold?**

- **Market (Policy) Leadership**
- Access to Capital
- Scale
- Brand
- Market Leadership
- Primary Care
- Unified Leadership
- Fiscal Transparency
- Management Of Risk
- Analytics
- Cost Management/Quality of Care
Summary thoughts
I don’t think healthcare is broken….but it is painfully struggling to manage change
We are just beginning to appreciate the perverse incentives that get in the way of change….and experiment with the alternatives
In the future AMCs will deliver needed complex comprehensive care in a much more efficient way to serve their communities and positively impact health
Change will occur….slower than we think in 2 years and faster in 10

The opportunities
“Being challenged in life is inevitable, being defeated is optional.”
— Roger Crawford

‘A healthy attitude is contagious but don’t wait to catch it from others. Be a carrier.’
— Tom Stoppard