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A QUALITY AND COST COMPARISON OF ACADEMIC AND NON-ACADEMIC HOSPITALS

Announcer: Welcome to Navigant On Healthcare, offering insights for healthcare leaders striving for success in an evolving industry.

Host: Welcome to Navigant On Healthcare. I'm your host, Alven Weil. Today we are happy to be joined again by Chris Stanley, MD. We'll be discussing a recent study he co-authored on academic medical center quality, cost, and value-based program performance compared to non-AMCs. Dr. Stanley is the director of Navigant's healthcare practice with more than 25 years of health system and payer executive leadership experience.

This includes successfully leading population health efforts for Catholic Health Initiatives' 100+ hospitals across 17 states and serving as senior medical director at United Healthcare. Chris is an expert on value-based models like MACRA, bundled payments, ADCOs, and clinically-integrated networks. If that isn't enough, he is also a trained pediatrician and a retired U.S. Army major. Dr. Stanley, like I said last time, we are not worthy, but thank you so much for joining us today.

Dr. Chris Stanley: Thank you very much, Alven, really appreciate the opportunity and the warm intro.

Host: Dr. Stanley, you recently co-authored analysis that compares academic medical centers and non-AMCs on a variety of cost, quality, and value-based metrics. If you would, please give us a quick summary of the results.

Dr. Stanley: Thanks, Alven, I'd love to do that. First, a couple of level-setting comments about academic medical centers, or AMCs. They're definitely a vital component of the care delivery system in the United States and they offer services that are really unmatched by their non-AMC competitors. AMCs really do need to make ongoing investments and unique services around specialized facilities, equipment, personnel, especially sub-specialty and quaternary type of care, as well, but does really make them very unique.

Additionally, AMCs have a very strong reputation for cutting-edge, specialty care and what's somewhat interesting to me, is that our previous experience actually has found that most academic center admissions and procedures could actually be performed in a

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community hospital. This leaves academic medical centers and large non-AMCs ultimately competing for the same type of clinical business. Again, while some AMC business and cases are very unique to them, they're the only ones that can do it, there's really a lot of competition between the two because the same types of cases could be providing services at both types of facilities.

The large volume of care able to be, therefore, provided at community hospitals, combined with the pressure being applied by Medicare, commercial payers and others to address cost and quality, or ultimately value, is putting a lot of pressure on academic medical center reimbursement rates and operating margins, as well as their ability to continue supporting their mission, including their research mission, as well. This scenario reinforces the need for AMC quality and cost performance to be on par with, or better than, their large, non-AMC counterparts.

That being said, let me share a little bit of our results. First, our analysis found that many AMCs have work to do in cost and quality areas. A few specific thought points here. One is, while we've seen improvement from 2015 to 2017 in our study, we actually saw median wage and case mix index adjusted cost per case was 5.8 percent higher at AMCs. This, specifically, was in 2017, the last available year of information. For an average academic medical center, that equates with $3.1M in average added annual operating expense. For at least traditional fee-for-service Medicare beneficiaries at the AMC, that amount actually quadruples to approximately $12M for low performing AMCs, compared to the high performers.

Additionally, we found little relationship between higher operating costs and better, quality scores at both AMCs, as well as non-AMCs. I would say from a clinical viewpoint I would have thought, potentially, that a higher cost would have actually translated to higher quality scores or, potentially, exactly the opposite, that poorer quality led to higher costs, but, in fact, we really saw no significant relationship. The quality scores were actually 4.4 percent greater at hospitals with lower cost, again -- not a very significant difference there at all.

Additionally, while Medicare value-based program performance improved significantly from 2016 to 2018, academic medical center scores still do trail non-AMCs, with AMCs actually receiving more significant program penalties under these Medicare-based programs.

Host: Chris, did anything really jump out at you as surprising, based on the results of this analysis?

Dr. Stanley: No, but I think the main thing that was a bit of a surprise for me...I wasn't anticipating it as a clinician, is the lack of correlation between quality and cost. As I mentioned a couple minutes ago, I believe that the common view of clinicians and others is that high reimbursement needs to support high cost because better care is being provided that translates into higher quality scores. What I was a bit surprised was that correlation really is not there. That was the biggest "ah-ha" for me, and I think it is very telling for academic medical centers, policy makers, and others, that we don't necessarily need to pay more for services in order for high quality to be provided.

Similarly, if you're an academic medical center you may not be able to justify higher costs, with the rationale that quality is going to be higher. That was probably the biggest surprise for me.

Host: These are very interesting results, to say the least. In your opinion, what do they mean for AMCs?

Dr. Stanley: First, I'd say cost and quality outcomes further emphasized across the industry, including through value-based payment models that CMS actually has even made some recent announcements for how they're moving down the value-based route even further, is that AMCs financial health will be dependent upon further quality and cost improvements. AMCs are going to face additional financial pressures and there are several trends that are really driving this.

One of those is that quality indicators are driving patient care decisions, or patient choice decisions. So, consumers are increasingly looking to value-based program indicators, transparency programs, looking at quality outcomes and cost to decide where to seek their care. Certainly, we believe that poor performance on metrics like that are going to directly impact patient volumes, especially commercially insured patients and the ones that are on high deductible-type health plans.

Secondly, growing revenue at risk through alternative payment models is going to continue to expand and grow and AMCs need to figure out how to be successful and sustainable in alternative payment model-type programs. If AMCs have poor performance on quality measures and/or cost measures, that's going to directly impact their top line and their bottom line from a revenue side and in their sustainability as an ongoing model.

Partnerships definitely impact performance, so as we think about accountable care organizations, or ACOs, they're looking to influence patient choice decisions, where patients are seeking care, how care is being provided, where their physicians are referring patients to. They're going to need to be more selective in their choices and their partnerships, and this applies to Medicare Advantage, traditional Medicare under ACO-type programs, commercial programs through clinically-integrated networks, and again, facilities with poor quality and/or higher costs are really not going to be the preferred providers and referral centers for those physicians and those organizations that they're looking to address cost and quality of care.

Again, patients are making choices, organizations themselves through alternative payment models are going to be directly impacted, and how they as academic medical centers are going to be used by community physicians and referred to are all going to be directly impacted by these types of results.

Host: Dr. Stanley, what approaches would you suggest AMCs can implement to create greater value and to minimize these negative implications from this analysis?

Dr. Stanley: Alven, I think there's a few things that are important to keep in mind here. First is, to understand the results of this study, to not dismiss the importance and the value of cost and quality in their strategic decisions, and the direction that they are heading as a leadership team in the organization. More operationally, I highly encourage them to use industry-wide benchmarking data, looking at performance against peers to really obtain a true snapshot of their outcomes and improvement potential.

By the way, here I would especially emphasize that peers are not just other academic medical centers in their local region, or national areas, but peers also are going to include community-based hospitals that are providing substantially similar care to similar types of cases of what they're providing at the AMC. Secondly, is they do need to engage their leadership, their physicians and other staff for improvement strategies so that employees feel the changes that are being done with them, not to them, basically engaging them as an organizational-wide quality and cost improvement initiative.

Again, that is not owned by just the CFO or just the chief quality officer. This needs to be an organizational strategy that engages all employees, physicians, and staff. Next is, approach this from a consumer or a customer viewpoint as well, or lens. It's important to understand how they seek care, how they're going to be influenced by provider network relationships across the care continuum, how they're going to be making choices with their feet and with their wallet, and ultimately developing common standards for access, quality, and cost across all of the different parts of their organization so, again, applying a consumer lens.

Next, last for now anyway, is look at evidence-based clinical protocols. Leverage those, incorporate those in your day-to-day clinical practice. Clinical variation of care has been widely-recognized as being a challenge for organizations. There are some great tools that we can, as an industry, bring to limiting unwarranted clinical variation and improving outcomes, as well. That will address things like patient throughput in hospitals, care transitions back to the community, physician preference item selection. If we think about bundles and episodes, or lower cost of care, again, having a more consistent way of providing care whether it's around asthma, diabetes, joint replacements or other types of solutions so that there's more consistency, standardization, and driving ultimately to better quality outcomes and lower cost.

Host: Dr. Stanley, any final thoughts?

Dr. Stanley: I think I'd leave you and the audience, Alven, with a couple of thoughts. One is: academic medical centers definitely play a unique and a vital role in healthcare delivery across the United States. They recognize that they are uniquely different and have unique challenges, as well. We definitely depend heavily upon them and we want to make sure

that they are going to be successful in the healthcare delivery system in the future. That said, I think what we're emphasizing with this new study and polite comparison information is: there's a changing competition landscape for AMCs that they may not have been aware of before and cost and quality are ultimately going to be the name of the game for success in the future as they are competing with community hospitals, other organizations, reorganizing themselves to deliver ultimately the value that they hope to bring to their communities.

Again, I think I would leave the audience with the recognition that the landscape is changing, it's very competitive, cost and quality are going to be the name of the game. We highly encourage academic medical center leaders to incorporate these thoughts, this study, this analysis and output, and their go forward strategy as well. Appreciate the opportunity, Alven, to share my thoughts. I'm very happy to be a co-author of this particular study that, again, I think is very meaningful for the industry.

Host: Excellent, Dr. Stanley, thank you so much for joining.

Dr. Stanley: Thanks for the opportunity.

Announcer: That concludes today's episode. Be sure to check in with us for future installments on the Navigant On Healthcare podcast series on navigant.com/healthcarepodcast. Navigant On Healthcare is a podcast series produced by Navigant's healthcare practice. If you enjoyed this episode, please share with friends and colleagues on social media. Learn more at navigant.com.