

# Strategies for Surgical Department Success in the Value-Based Payment Era

Julian D. (“Bo”) Bobbitt, Jr., J.D.\*



There are still some parts of the country where a typical conversation about value-based payment (“VBP”) models, such as accountable care organizations (“ACOs”), might find them described as a flawed government theory, as part of “Obama Care,” the “next big thing” to save health care like gatekeepers and capitation supposedly were, another wedge between me and my patient, and so on. In other parts of the country, there are stirrings of interest in VBP. Still rare is the acknowledgment that VBP and ACOs are inevitable and that they might present strategic opportunities for proactive leaders.

**WHY IS CHANGE INEVITABLE?** Health spending is unsustainable, even before coverage expansion of the 2010 federal health reforms. With 19% of Gross Domestic Product (“GDP”) being the rough estimate of the amount the United States can collect in taxes and other revenues, by 2035, Medicare and Medicaid are predicted to consume 13% of GDP and health care costs will consume 31% of GDP. In other words, health care alone will cost well over all we collect. By 2080, absent drastic change, Medicare and Medicaid will consume all of our tax and other revenues, and total health spending will claim 46% of GDP. The rest—defense, education, roads, etc.—we can only pay for by borrowing. President Obama was the first President facing bankruptcy of the Medicare System during a term in office.



There is consensus that much of this is avoidable. The now-famous *New Yorker* article by Dr. Atul Gawande showing Medicare spending to be twice as high in McAllen, Texas as in El Paso, became required reading in the White House. Dr. Gawande wrote: “The real puzzle of American Health-care...is not why McAllen is different from El Paso. It’s why El Paso isn’t like McAllen. Every incentive in the system is an invitation to go the way McAllen has gone.”<sup>1</sup>

The Congressional Budget Office Report on the ACO’s predecessor, the Bonus-Eligible Organization, includes this rationale: “[P]roviders have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists.” These dysfunctions in our current system, for which the ACO is seen as a partial remedy, have been given much of the blame for our country’s health care system costing 50% more as a percentage of GDP than any other in the world, but ranking only 37<sup>th</sup> in overall health and 50<sup>th</sup> in life expectancy.<sup>2</sup>

Because of the crisis, drastic efforts at health care cost reform are inevitable. President Obama stated it bluntly: “So let me be clear: If we do not control these costs, we will not be able to control the deficit.”<sup>3</sup> Private insurers see it, too. The President of Blue Cross and Blue Shield of North Carolina stated: “[T]he market must continue to change. The system that brought us to this place

<sup>1</sup> Gawande, M.D., Atul, *The Cost Conundrum*, *The New Yorker* (June 1, 2009).

<sup>2</sup> World Health Organization, *World Health Statistics*, 2009.

<sup>3</sup> President Barack Obama, interview excerpt, July 23, 2009.

is unsustainable. Employers who foot the bill for workers' health coverage are demanding that BlueCross identify the providers with the highest quality outcomes and lowest costs."<sup>4</sup>

Flattening the cost curve is possible through VBP's marketplace incentives without rationing care, imposing new taxes, or drastically cutting provider reimbursement. Doing nothing is not an option, and all the alternatives are unacceptable to academic medical centers. In short, there is no "Plan B." Even without federal health reform, the sheer unsustainability and flaws of our current system are driving the movement to payment for value, not volume. Recent data showing the abatement of Medicare cost increases suggests that VBP is working and will give added momentum to the shift.

The payment for health care is moving inexorably and with growing swiftness away from fee-for-service's "pay-for-volume" to VBP. These changes are coming simultaneously from different directions such as Medicare's Value-Based Purchasing, ACOs, bundled payment initiatives, and aggressive steerage by private payors to narrow networks, limited to just a few high-value health systems and networks. For academic medical centers in general, and surgical departments in particular, the question is not "whether" to prepare for value-based care, but "how?" There are core capabilities essential to academic medical success.



**WHAT ADDITIONAL CHALLENGES TO CLINICAL TRANSFORMATION TO THE VALUE MODEL WILL ACADEMIC SURGERY FACE?** In his *Academic Medicine* article entitled *The Future of Academic Surgery*, Dr. Roy Smythe stated: "John Gardner, the founder of Common Cause, one of the original architects of Medicare, and an advisor to several presidents, once stated: 'A society whose maturing consists simply of acquiring more firmly established ways of doing things is headed for the graveyard—even if it learns to do these things with greater and greater skill. In the ever-renewing society, what matures is a system or framework within which continuous innovation, renewal, and rebirth can occur.' Academic surgery is a microcosm of the [many challenges facing] greater academic medical enterprise, albeit with a few idiosyncrasies. ... We will have to think and act innovatively.... Doing the same things we have been doing, even if we improve them incrementally, will simply not, as noted by Gardner, be sufficient to meet those challenges."<sup>5</sup>

Academic medical centers ("AMCs") are the nucleus of the health system. They train doctors, discover new treatments, and care for the most challenging patients. AMCs graduate nearly 17,000 MDs every year, provide more than 40% of charity care, and account for 20% of all hospital admissions, surgical operations, and outpatient visits.<sup>6</sup> Yet, they face multiple systemic challenges that threaten their profitability. Though consumers value the AMC brand, 78% of consumers indicated in a PwC Health Research Institute survey that they would not be willing to pay a higher premium to access care at an AMC<sup>7</sup>. Meanwhile, funding sources are changing, research costs continue to rise faster than sources of funding, and AMCs are perceived to be "high-cost" providers in an accountable care environment focused on lowering costs. Therefore, according to the PwC survey, tomorrow's AMCs must revamp and recombine the tripartite AMC missions of clinical care, research, and education.

<sup>4</sup> Brad Wilson, President of BlueCross BlueShield of North Carolina, *The News & Observer* (January 29, 2011).

<sup>5</sup> Smythe, M.D., W. Roy, *Academic Medicine*, *The Future of Academic Surgery*, 2010; 85(5); 768-74; <http://www.medscape.com/viewarticle/723240>, (2010).

<sup>6</sup> 2011 AAMC Databook: *How Do Teaching Hospitals Serve America's Communities?*, AAMC.

<sup>7</sup> PwC Health Research Institute, *The Future of the Academic Medical Center*, <http://www.pwc.com/us/en/health-industries/publications/the-future-of-academic-medical-centers.jhtml>. PwC commissioned an online survey of 100 AMC leaders; however, not all survey questions received responses from the entire group of participants. References to data from the PwC Health Research Institute AMC Leader Survey are based on responses received.

AMCs will also need to address their own organizational shortcomings around decentralized academic administration, inefficient infrastructure, and a lack of clear business intelligence capabilities.

## II. CHANGE IS COMING; IT WILL BE BIG—WHAT SHOULD ACADEMIC SURGERY DO ABOUT IT?

**A. Strategies Applicable Generally** – First, all health care organizations today should assess what its future state value-based care model needs to look like. They should understand the core capabilities needed for success, assess existing competencies, and develop a plan for “closing the gap” to obtain the remaining needed capabilities.

According to Deloitte LLP, a viable health system value-based care model must contain the following six core capabilities:

### 1. Leadership and Governance

- Governance system of accountability;
- Physician leadership decision-making rights and responsibilities;
- Performance measures to inform clinical and business decisions; and
- Communication and change management approach.

### 2. Clinical Integration

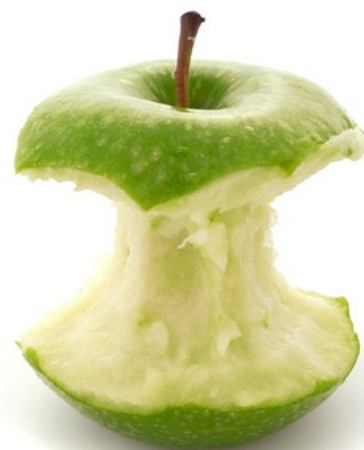
- Care coordination and transition processes;
- Clinical protocols and guidelines;
- Tools/processes to support integration and care coordination;
- Quality, safety, and outcomes;
- Population health management/care management/disease management (vs. case management); and
- Patient engagement/satisfaction.

### 3. Business Operations

- Process standardization;
- Service operations;
- Customer relationships;
- Rating and underwriting;
- Performance improvement;
- Resource management;
- Cost management;
- Marketing and sales;
- Legal and compliance; and
- Revenue cycle.

### 4. Information and Integration Services

- Clinical information systems;
- Data warehouses;
- Analytics and business intelligence;
- Interoperability and data sharing;
- Population health reporting; and
- Secured health information.



## 5. Network and Physician Alignment

- High-value network composition;
- Physician alignment;
- Community/public health programs and services engagement;
- Provider evaluation and performance metrics; and
- Quality and performance reporting.

## 6. Incentive Alignment

- Economic model;
- Value-based risk arrangements;
- Distribution model;
- Compensation and incentives; and
- Third party agreements.



**B. Strategies for Surgical Departments** – The above strategies apply to all stakeholders. They are designed to maximize value, the highest quality at the lowest cost for a patient population. But what specifically should you do?

**1. PwC Health Research Institute** – Here are five strategies recommended by PwC:

**“Strategy # 1—Build the Brand by Holding Faculty Accountable for Cost and Quality** –

AMC leaders said their organizations are complex to manage and that multiple layers and silos create enormous variation. The new payment models will be based on meeting quality metrics and controlling costs across the continuum of care. Three-fourths of AMC leaders said they would respond to funding and revenue challenges by improving quality outcomes.

However, at the same time, well-entrenched faculty and organizational structures have made it difficult to address costs and quality. AMCs must place an equal focus on both reforming organizational structure and improving quality outcomes.

**Strategy # 2—Become Part of a Larger Community Network** – Fifty-nine percent of the consumers surveyed by PwC said they were likely to seek treatment from a community hospital if it was associated with an AMC. As AMCs engage in network agreements, this consumer view will have a positive impact on attracting patients and referring care.

**Strategy # 3—Push the Envelope on New Kinds of Extenders to Increase Effectiveness**

– New health care extenders such as telemedicine, collaborative classrooms, simulation technology, and shared services will dramatically change how AMCs deliver care and train doctors and scientists. Sixty-nine percent of AMC leaders surveyed by PwC said they are likely to adopt extended services through telemedicine as an important relationship model. This commitment to technology will allow AMCs to reach new patients and generate cost savings.

**Strategy # 4—Become an Information Hub to Realize a Return on HIT Investment** –

AMCs have millions of patient records but no way to access them. Sixty-five percent of AMC leaders indicated that their institutions will collaborate with other research institutes or medical centers to share electronic health records (“EHRs”) during the next five years. AMCs will utilize technological



## Value Based Payment Strategies Continued

advances, many of which have been developed by other AMCs, to share data and ultimately enhance scientific discovery through inter- and intra-AMC data sharing.

**Strategy # 5—Align the Research Pipeline with Clinical and Business Strategies** – Sixty-two percent of AMC leaders surveyed by PwC indicated that coordinating translational research will be a high priority at their institutions during the next five years. As AMCs follow this path, they will capitalize on their existing strengths and develop transformational treatments and cures.”<sup>8</sup>

**2. AASA Conference Presentation** – You may recall Dr. Wayne Meredith’s comments at the Association of Academic Surgical Administrators conference on October 7, 2013. During his presentation, “Moving Academic Surgery from a Profit Center to a Value Center,” he emphasized the urgency to move to value and gave practical tips on creating an efficient high-value system, including the key take-way: “Culture trumps strategy, structure, even reason.” He shared several practical strategies, including:

- Over-resourced facilities (*E.g.*, routine care delivered in expensive hospital settings)
- Under-utilization of expensive clinical space, equipment, and facilities
- Poor utilization of highly-skilled physicians and staff
- Over-provision of low- or no-value testing and other services in order to justify billing/follow rigid protocols
- Long cycle times
- Redundant administrative and scheduling personnel
- Missed opportunities for volume procurement
- Excess inventory and weak inventory management
- Lack of cost knowledge and awareness in clinical teams

Such cost reduction opportunities do not require outcome tradeoffs, but may actually improve outcomes.<sup>9</sup>

**IV. CONCLUSION:** Value-based payment is coming. It will require transformative change for all health care stakeholders. Culture change is the biggest challenge. Academic medicine provides some of the most vital benefits to our health care delivery system, yet, ironically, faces more challenges and risks to effect this transformation than other segments of the care delivery spectrum. Incremental change will not suffice. Yet, a pathway for success is available to those who are willing to convert their department to being a value center. As Charles Darwin said: “It is not the strongest or the most intelligent who will survive, but the one most responsive to change.”

\* Mr. Bobbitt is a senior partner and head of the Health Law Group at the Smith Anderson law firm in Raleigh, North Carolina. He has many years’ experience assisting physicians form integrated delivery systems. He has spoken and written nationally to physicians and health systems on the strategies and practicalities of forming or joining ACOs. This article is meant to be educational and does not constitute legal advice. For additional information, readers may contact the author ([bbobbitt@smithlaw.com](mailto:bbobbitt@smithlaw.com) or 919-821-6612).



<sup>8</sup> *Id.*, at p. 6.

<sup>9</sup> Meredith, M.D., Wayne, The Association of Academic Surgical Administrators 5<sup>th</sup> Annual Conference, *Moving Academic Surgery from a Profit Center to a Value Center*, (Oct. 7, 2013).