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Perspective

Balancing AMCs' Missions and Health Care Costs — Mission Impossible?

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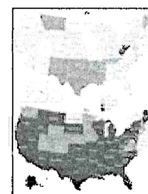
When major provisions of the Affordable Care Act (ACA) are implemented next January, few institutions will feel the pressure to control costs more acutely than academic medical centers (AMCs), which must balance the imperatives of clinical care with cost-intensive missions in research, teaching, and community health. Massachusetts AMCs don't have to guess at the law's likely impact: in 2006, our state launched its own health care reform involving principles and policy solutions similar to the ACA's. Massachusetts therefore provides a laboratory for gauging the effects of such reforms.

Having largely solved the insurance problem, Massachusetts passed sweeping cost-control legislation in 2012, including setting a target ceiling on growth of total medical expenses. Although Massachusetts' health care costs are among the highest in the country in absolute terms, they're among the lowest when adjusted for cost of living (see maps).[1] Nonetheless, AMCs' share of hospital admissions is higher in Massachusetts than in any other state, and AMCs' costs are typically higher than those of non-AMC providers.[2] As a national hub for medical research and education, Massachusetts must carefully limit the growth of health care costs without undermining the future of this important resource.



Average Premiums for Employer-Based Insurance Plans for Population Younger than 65, as Percentage of Median Household Income, 2003 and 2011

At the state's two largest AMCs, we've addressed this challenge in part by using known methods for improving access, continuity, and care coordination, relying heavily on data and measurement.[3] We call this approach population health management, and implementing it poses different risks and challenges for AMCs than for others. Balancing efforts to contain costs against investment in our missions involves trade-offs among important goals. We view meeting this challenge as a key contribution we can make to health care's future.

In 2011, Brigham and Women's Hospital (BWH) and Massachusetts General Hospital (MGH), through Partners HealthCare, chose to participate in risk-based contracts with commercial payers and the Centers for Medicare and Medicaid Services as a Pioneer Accountable Care Organization. Under these contracts, we share financial risk for the increase in total medical expenses for patients who see primary care physicians (PCPs) in our network. If our cost growth exceeds that of a comparison group, we pay penalties; if it's lower than that group's, we share in the savings. These contracts cover more than 400,000 patients — more than one third of the patients who receive care in our hospitals annually. In addition to the financial incentive, these contracts help us restrain cost growth by providing a measuring stick to assess our progress in developing and deploying innovative care-delivery processes that are more efficient and more satisfying to patients and that result in higher-quality care.

We've focused first on primary care as the hub for managing populations' care through preventive services, care for chronic illnesses, and care coordination for high-risk patients. We're expanding our cadre of employed PCPs and advanced practice nurses and are committed to ensuring that all our primary care practices become certified by the National Committee for Quality Assurance (NCQA) as Patient-Centered Medical Homes. So far, about 350 providers are engaged in practice redesign, and six lead practices have achieved NCQA recognition.

The most expensive component of this expanded investment is 71 "high-risk care managers" who work closely with PCPs, each coordinating the care of approximately 200 high-risk patients. This program arose from a successful Medicare demonstration

project started at MGH in 2006 and expanded to BWH in 2009. Independent evaluations have found cost reductions of 2.5% to 19% for the care of multiple successive cohorts of enrollees — for total taxpayer savings of more than $50 million. The nearly three-to-one return on investment has made this program the centerpiece of our efforts and given us greater confidence to take on further cost-containment challenges.

Unlike the failed managed-care efforts of the 1990s, our initiatives involve our specialists as well. Specialists' decisions drive a large fraction of costs, especially for commercially insured populations. Having assessed our primary care population's unmet needs, we're adding clinical staff in such areas as mental health, general cardiology, dermatology, and physical therapy. We are changing the way we provide care, using innovative approaches such as referral management, virtual visits, one-time home nursing visits, team-based care, and home telemonitoring. We have a process for actively reviewing and redesigning the way we deliver care, condition by condition, that emphasizes optimizing the patient's care experience (continuity of information, management plan, and relationships) and the efficient delivery of services throughout an episode of care. For example, we've reduced admissions for transient ischemic attacks by making the required testing immediately available for outpatients; we've improved diabetes care by automating referrals to diabetes counselors; and we've begun reviewing specialist referrals to identify opportunities for providing consultations without requiring face-to-face visits. Changing these processes presents unique challenges to AMC physicians, partly because care delivery is only one of their responsibilities, in addition to research and teaching.

These changes in clinical process require additional investment in information systems and analytic resources. To ensure consistent clinical communication and assess our progress in population health management, we're consolidating our clinical and administrative systems onto a single electronic platform. This new infrastructure requires investment, which is not provided by the risk-based contracts, and success in these contracts means lower clinical revenues. Moreover, government payer rates have not kept pace with inflation for more than a decade. Therefore, funding for these new AMC costs must come from growth in regional, national, and international referrals and reductions in our cost structure — a difficult and perennial problem that we are addressing.

A second difference from 1990s managed care is our development of a coordinated process for sharing risk across our AMCs and physician groups. Our performance framework encourages shared practices for managing care for populations rather than holding each physician accountable for individual patient costs. Accordingly, the financial risk shared with payers is held at the level of the integrated delivery system. In turn, we've created an internal incentive system designed to accelerate and reinforce the adoption of primary and specialty care programs and encourage local innovation and strong performance on quality and safety metrics. Each AMC has invested in the infrastructure required for its physicians to meet the internal incentive goals.

Although we have only 18 months of experience with risk-based contracts, our approach is showing promise. Our cost trends have been lower than local and national comparison benchmarks,[4] suggesting that even at the current historically low rates of cost escalation, our efforts are paying off. Nonetheless, challenges and tensions remain — among them, balancing the imperative of cost-efficient, high-quality clinical care with our research, education, and community health missions, especially as federal budget cuts and payment rule changes impose substantial pressure. We do not yet have solutions to these difficult challenges, but we're committed to innovative approaches to solving them.

Fortunately, our teaching mission is wholly compatible with our care-delivery changes: we are educating providers and physicians-in-training about the future of clinical care. New payment systems encourage a convergence of AMCs' clinical and community health missions: investments in community health have historically been charitable but now promise to reduce medical expenses for affected populations. The impact on basic, clinical, and population-based research is less clear. Innovation distinguishes AMCs, and ensuring that basic biomedical discovery flourishes as we invest in care delivery will require vigilance.

AMCs' complex organizational structures and historical focus on tertiary inpatient care may appear incongruent with success in contracts requiring commitment to change and reduced use of hospital services. Charting our course under the current economic pressures won't be easy. But our AMCs have built their reputations by addressing society's most pressing health care challenges, and today's central challenge is the rising cost of health care. Fortunately, AMCs specialize in innovation. We must now apply that capability not just to scientific aspects of medical care but also to the systems delivering it.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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