



BASE MODEL OR FULLY EQUIPPED?

**AMCs SEEK THE RIGHT
CARE DELIVERY VEHICLES
FOR THEIR COMMUNITY
PLATFORMS**

Academic medical centers (AMCs) have over the years been adding community hospital platforms to their networks, either to expand into a geographically desirable location or to provide a chassis where clinical activity can take place away from the main campus. But now, against a backdrop of payment reform, a third reason has emerged: to lower the per-unit cost of care across their networks.

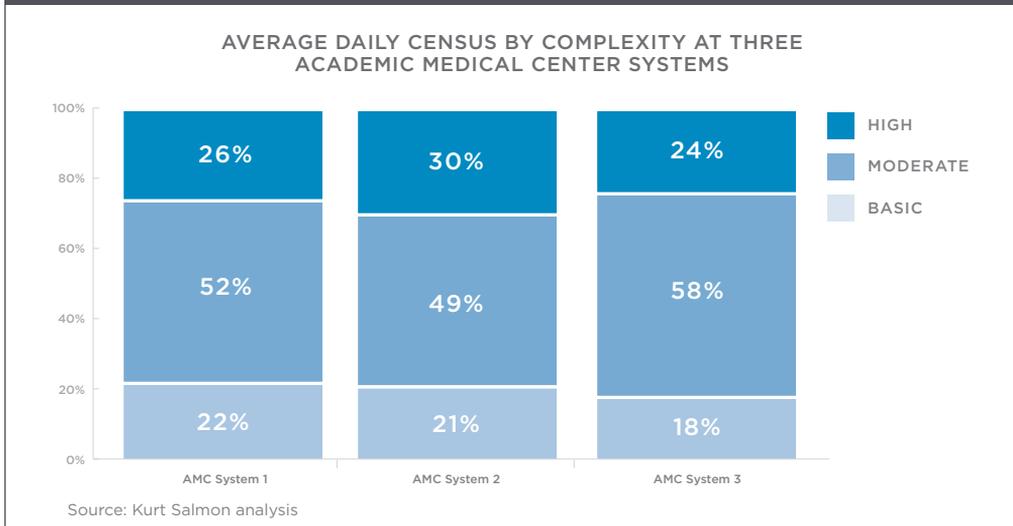
In their discussions with commercial payors, AMCs have long relied on their brand and reputation to justify a premium, a practice they often extended to their

community-based satellite hospitals. But many AMCs have also applied their traditional academic operating model to those satellites, a model that includes teaching and research capabilities similar to the main campus, as well as inefficiencies associated with trying to develop subspecialized care. They've essentially tricked out every chassis in their fleet of care delivery vehicles, adding 4WD and a turbo engine even to vehicles making fair-weather deliveries. And that means that as payors increasingly seek the lowest-cost options, AMC satellite hospitals

EXHIBIT 1: A complexity-based segmentation framework helps networks direct patients to the most cost-effective care.

| LEVELS OF COMPLEXITY | |
|----------------------------|--|
| HIGH COMPLEXITY | Volume that comes to the institution due to its singular capabilities and resources (e.g., transplants, “botched cases”) |
| MODERATE COMPLEXITY | Volume for which the institution and its physicians compete directly with other providers and their medical staffs (e.g., spine, CABG) |
| BASIC COMPLEXITY | Volume that comes to the institution primarily due to access and convenience, but which could be treated at any other hospital facility (e.g., angina, births) |

EXHIBIT 2: Basic-complexity patients, which make up 10% to 20% of main hub AMC inpatient admissions, could be routed to lower-cost environments.



will be unable to effectively compete against non-AMC community providers that will themselves be reducing costs.

In order for their satellite facilities to both survive and thrive, AMCs need to change the way they deliver care at their community hospital entities to be competitive with other options in their respective markets—indeed, the very reason that AMCs are motivated to build such community-based networks in the first place.

Resisting the Call of Bells and Whistles

AMCs exist to push the boundaries of medicine—they are where future clinicians go to train and where much of the research and discovery that will serve as the foundation for tomorrow’s cutting-edge care is pursued and developed. But given the high cost of teaching and pursuing research, the cost of providing patient care—AMCs’ third core function—is similarly high, whether the complexity of that care is also high or merely basic. And so with an eye to lowering the

overall cost of delivering clinical care, AMCs have been augmenting their so-called “main hub” facilities with community-based satellite facilities that can effectively treat basic-complexity patients without the added costs of AMC technologies, staffing levels and teaching models. (See Exhibit 1.)

The cost-reduction opportunities are significant. The number of basic-complexity patients at main hub AMCs ranges from 40% to 55% of all inpatient admissions and accounts for roughly 10% to 20% of the total census at any given time throughout the year, according to data collected by Kurt Salmon from AMCs across the country. (See Exhibit 2.) For a 500-bed hospital, that means there are some 15,000 to 16,000

discharges annually that could potentially be seen in the lower-cost environment, patients who tend to be younger, have shorter lengths of stay and have medical issues that are episodic rather than chronic in nature (for example, appendicitis, basic spine or joint procedures, etc.).

Bigger Engines Aren’t Always Better

Using a satellite hospital to shift basic-complexity patients off the main campus has been proven to have a positive financial impact on AMCs’ overall systems in three ways:

1. Incremental margin improvement due to treating the same patient but in a lower-cost environment. This is primarily a result of the cost differential on a per-day

EXHIBIT 3: AMCs can save significantly by directing more traffic to satellite facilities.

COMPARING BASIC-COMPLEXITY ADMISSION COSTS AT ACADEMIC MEDICAL CENTERS AND THEIR SATELLITES

| | AMC 1 | SATELLITE 1 | AMC 2 | SATELLITE 2 | AMC 3 | SATELLITE 3 |
|------------------------|---------|-------------|---------|-------------|---------|-------------|
| Number of Admits | 24,000 | 1,500 | 7,500 | 3,800 | 14,700 | 8,200 |
| Direct Costs per Admit | \$3,100 | \$2,000 | \$1,700 | \$1,300 | \$2,700 | \$1,700 |
| Direct Costs per Day | \$1,200 | \$850 | \$700 | \$400 | \$1,100 | \$800 |

Source: Kurt Salmon analysis of client AMC inpatient records, 2009–2011

EXHIBIT 4: The contribution margin for high-complexity patients can be 10 times higher than lower-complexity patients.

| CONTRIBUTION MARGINS, DOLLARS PER ADMIT | | | |
|---|--------|--------|--------|
| | AMC 1 | AMC 2 | AMC 3 |
| High Complexity | 21,700 | 23,100 | 19,400 |
| Basic Complexity | 900 | 3,400 | 2,300 |
| Difference | 20,800 | 19,700 | 17,100 |

Source: Kurt Salmon analysis of client AMC inpatient records, 2009–2011

basis. Notably, the margin differential can vary greatly depending upon the payor mix of patients seen at the various campuses and the contracting terms with payors. But based on data provided from multiple academics that run and staff satellite facilities, Kurt Salmon found that, on average, there is a 40% differential in direct cost per patient day for basic-complexity cases treated at the satellite facility vs. the main campus, as illustrated in Exhibit 3.

2. Backfill opportunity to replace basic-complexity patients with higher-complexity, higher-margin patients who

require the high-intensity resources available only at an AMC. This assumes the current inpatient chassis at the main campus is at or near full capacity, and that there is a market opportunity to treat more higher-complexity patients at the main campus if basic-complexity patients are shifted to the satellite facility. It also assumes there is unused bed capacity at the satellite facility, which in Kurt Salmon’s experience is typically the case in most geographies. Although the AMC will not be able to replace its basic-complexity discharges with high-complexity admissions on a 1:1

basis, due to the difference in length of stay, high-complexity cases typically have a contribution margin more than 10 times greater, on average, than those of basic-complexity admissions. (See Exhibit 4.)

3. Deferred capital expenditures by using latent capacity on the satellite hospital campus rather than building additional, high-cost capacity at the main campus.

While construction costs vary across the country, it has become increasingly expensive to build new hospital capacity. The average cost to build out a new inpatient tower is now well in excess of \$1 million per bed.

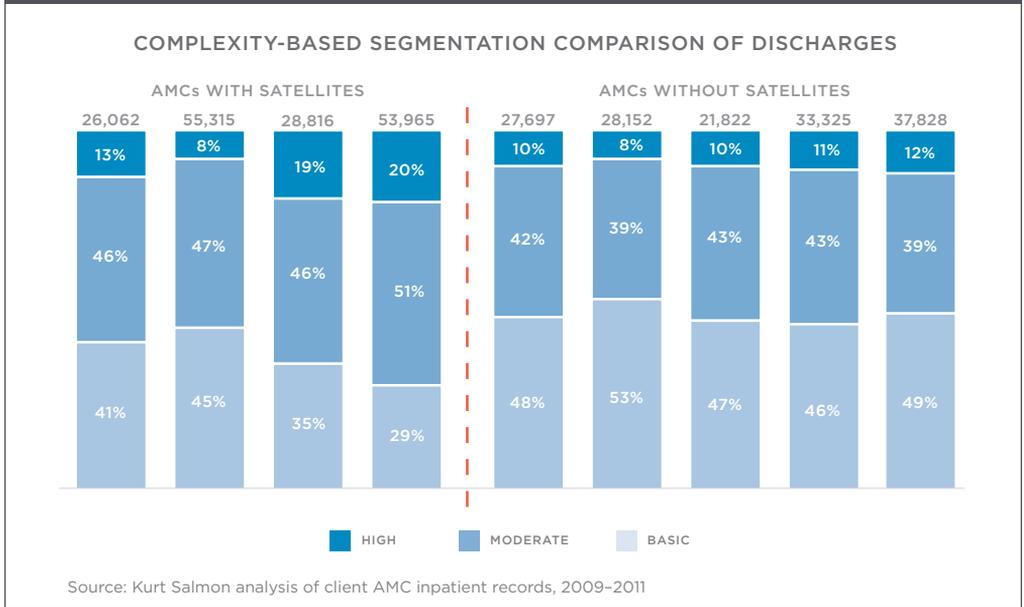
For AMCs, which are designed to teach and conduct research as well as to take care of high-complexity patients, the per-unit cost of their main campus facilities can be lowered only so much, given the expensive equipment, infrastructure and real estate required to operate them. But as payors move from a fee-for-service environment toward a value-driven one, the higher premiums that AMCs command aren't sustainable over the long term. Meanwhile, their community counterparts continue to broaden their service sets and improve efficiencies—in other words, to lower their costs even further relative to AMCs.

Tactical Trades: Cadillacs for Camrys

It's not feasible to shift all the basic-complexity cases out of the high-cost inpatient chassis and into other vehicles in the fleet; a certain number of patients will always access care through emergency departments, and physicians who see high-complexity patients will often also treat those same patients even when they present with cases of a more basic nature. Moreover, it can be difficult to get faculty to move their practices out to satellite facilities; they may, for example, have a hard time seeing the benefits of practicing in a community hospital environment and may not like being separated from the rest of their peers. From an overall network perspective, having a mix of academic and community physicians will make physician alignment vehicles, incentives and governance structures more complicated as well. Even so, numerous AMCs have shown that it is possible to reduce the overall percentage of basic-complexity cases seen at the main campus by utilizing a satellite campus strategy. (See Exhibit 5.)

In an attempt to reduce costs and improve margins, an increasing number of AMCs have been acquiring satellite locations in the

EXHIBIT 5: The average basic complexity levels at AMCs with satellites is 38% vs. 49% at AMCs without satellites.



community, where they can provide basic-complexity care at a lower per-unit cost than at the main hub. The number of AMCs with at least one satellite facility, defined as a separate inpatient platform owned by an AMC and located within a relatively similar geography, continues to grow; some of the highest-ranked hospitals and academic institutions in the country—including 16 of the 17 hospitals on the 2014 *U.S. News &*

World Report Honor Roll list—have at least one satellite campus as part of their system.

The satellites tend to be structured as community hospitals with two or three “anchor programs” that have faculty-centric care delivery models; indeed, most of the *U.S. News & World Report* Honor Roll members are staffed primarily with faculty physicians, although there is a variety of physician models in place and they continue

It is inevitable that academic systems will have to move to stringent productivity standards, slimmer staffing models, less protected time and fewer investments in “nice-to-have” technology.

to evolve. But by keeping a faculty-centric operating model, the satellites carry with them all the costs associated with training and access to subspecialists. And faculty who practice in the satellite hospitals often try to recreate the luxuries that exist at the main hub by demanding items such as cutting-edge technologies, 24/7 intensivist coverage and protected academic time. The satellite facilities’ per-unit costs, in turn, are oftentimes an order of magnitude higher than those of other community hospitals in their markets.

As payment models continue to evolve, certain AMCs may find it impossible to lower their per-unit costs to a point where, on a pure dollars-to-dollars basis, they are seen as being competitive with their community counterparts. But unless the clinical reimbursement environment continues to support price premiums for academic pursuits, sooner or later AMC satellites will have to let go of many of the luxuries that currently exist within the traditional academic operating model.

Over time, it is inevitable that academic systems will have to move to stringent productivity standards, slimmer staffing models, less protected time and fewer

investments in “nice-to-have” technology if they are to care for patients out in the community. The faculty themselves may be the largest barrier to adjusting the model, which means that alternative staffing vehicles with separate incentive models and structures may need to be considered in order to create a competitive delivery platform.

To be sure, questions remain as to who will ultimately pick up the tab for the tripartite mission—but this battle should not be fought by creating inefficiencies on strategically intended low-cost platforms. Ultimately, creating efficiency in clinical delivery is the key to effectively competing in a value-based world. And nowhere is that more apparent than in the community-based satellite facilities of AMCs. ❖

AUTHOR

Jared Averbuch, Senior Manager
jared.averbuch@kurtsalmon.com