Choose the Right Strategies and Technology to Improve Cost Performance in Health Care

written by Theresa Hush | November 16, 2017

Fee for Service (FFS) reimbursement is going the way of the dinosaurs, but many providers are ignoring the signals. Here are two clear indicators: Medicare's adoption of episodic cost models and the planned movement to financial risk models for both Medicare and Medicaid. Indeed, most Medicaid plans have now transitioned the majority of beneficiaries into managed care plans.

Private health plans, many of which were burned by capitated HMO plans in years past, are aligning with providers to develop ACOs and moving again toward risk. Recent health care mergers and acquisitions evidence a blurring of lines between health plans and health care organizations. Health care system consolidations continue to be a major trend, resulting in larger systems with employed physician practices. Additionally, we're seeing a spike in vertical acquisitions, such as the purchase of Advisory Board's Healthcare operations by UnitedHealth Group's subsidiary Optum, and PinnacleHealth's purchase of University of Pittsburgh Medical Center and other hospitals in Pennsylvania.

Despite these trends, most providers lag in adopting tools to measure and improve cost performance. Unwillingness to give up volume-based revenues in the short term and lack of cost data are two key factors. But equally important is the lack of experience and technology to focus on measurement and improvement of cost performance.

So, What Is Cost "Performance?"

Perhaps one reason that the industry has been so sluggish in curtailing health care costs is the lack of a good definition for "cost performance." At best, health plans and government have characterized acceptable cost performance by either what is missing (negative) or what others are doing (comparisons). "Acceptable" in that case means that there is no penalty associated with the cost, and there may be an incentive. Examples of unacceptable cost performance include:

Cost per patient or per episode higher than other providers;
Unnecessary admissions;
Readmissions;
Emergency room use, or ambulatory-sensitive inpatient stays.

Without a target and tactics to get to performance, providers tend to back into piecemeal cost initiatives that affect reimbursements now, such as reduction in readmissions, and use those as a proxy for comprehensive cost performance. This is a tactical mistake. At a minimum, during the time period when FFS continues to exist, providers should create and quantify their goals, covering at least these areas:

Per-patient costs according to conditions and procedures by patient risk level, inclusive of all settings of services;
Episodic costs for high volume procedures and inpatient medical stays.

Providers should calculate their vulnerabilities in the cost arena as part of cost performance strategy development. This starts with quality and outcomes. The lack of a comprehensive quality and outcomes performance measurement process—and a quality "reporting" initiative is not a substitute—has a direct link to cost performance.

Problematic medical decision-making processes—including failure to have protocols for the use of certain prescriptions, imaging, tests and treatments—will result in higher costs. Therefore, the first action for cost performance is to measure performance in quality and patient outcomes, adjusting for patient risk, and capturing the trend in patient outcomes and improvement.

In addition to the data that falls out of quality measurement, providers should focus on cost-specific areas:

- Collect and analyze cost data that is available from health plans and Medicare/Medicaid—and deploy a contract negotiation strategy with health plans that ensures the availability of such data;
- Compute in-network services by primary/referred specialists, and determine how much care is being rendered outside of the health system boundaries;
- Zero in on one the largest component of rising costs: imaging technology. Identify patients with multiple imaging or stepped up/down imaging to see patterns of care that may create unnecessary costs;
- Examine prescription drugs and costs to target use of brand name versus generics, or higher cost drugs that should have a protocol for use;
- Evaluate pricing and service strategies for imbalance in the costing of services. For example, Medicare data often shows that costs of outpatient services are higher than norms; this could result from pricing, inclusion of standing orders, or a higher risk population. Calculating this is key to finding the correct solution.

Invest in Technology for Cost Performance

Improvement in both quality and cost is an iterative process; the interventions for cost improvement are rarely clear cut, because the reasons are not known, and the solutions must be tied to the patient's protocol. Improving performance should be a process with an objective of identifying interventions that are or could be effective, measuring results along the way.

Health care systems are not always nimble users of their own systems. Expertise with both data and data analyses is uneven on the provider side, and the requirements will surpass the experience of most provider systems. The best solutions will be clinical data registries or other technology companies that offer both measurement and improvement of long-term outcomes and cost trends. Companies that can provide consultation and project management are important. In addition, the most desirable technology should permit the management of multiple cost and quality projects, manage health data of variable integrity, remap and identify missing elements, and have the ability to collect both provider and patient data.

Technology requirements span both purely technical infrastructure, as well as functionality and guidance:

General Requirements

Integrated patient data from provider source systems as well as external sources, such as claims from health plans; the system should be patient-centric, showing patient results across all clinician and hospital visits;
Capability of input or digital feedback from patients and providers;
Risk adjustment of patients by at least one standard methodology;
Patient visits include multiple diagnoses, patient attributes, clinical values (not proxy procedure codes);
Provider source data sufficient in detail to include specialty and subspecialty, and business details of the group and provider, and all transaction and coverage data for patient;
Views specifically for physicians;
Capability for patient-provided outcome data;
Analytics show measure results, trends, associations, effectiveness of interventions, variability in patients and provider comparisons.

Performance Measurement

Inclusion of cost measures and custom cost measures;
Cost measures able to distinguish primary and specialty physicians;
Ability to set care team, not just individual attributed physician, for custom projects;
Episodes of care bundles, especially those currently being field tested by CMS;
Ability to capture financial detail if provided;
Distinction of in-network and out-of-network services;
Analytics to show variation in care by patient, across types of patients, and by outcomes;
Trended outcomes as opposed to once-per-time-period outcomes.

Performance Improvement

Project functionality: ability to set population (and randomize patients if desired) by criteria, vet and exclude patients on basis of exclusion criteria, and establish project workflow;
Distinguish individual improvement projects;
Share data with physicians, including feedback;
Log and track interventions, like shared decision making or educational appointments;
Permit user to conduct activities for project, such as send out letters for patient outreach or log calls;
Allow use of survey and other data that is patient-identified;
Provide for pilot or tests of performance improvement projects.

Adopt Consumer-Friendly Approaches and Technologies That Go Beyond Cost Performance

Because the shift in cost sharing to consumers is one of the key trends driving the need to curtail costs, health care systems also need to evaluate and redesign processes for consumers. Specifically, providers will need to adopt methods that will provide better service to consumers and safeguard them from unnecessary and excessive costs. These service changes can be tested as part of Cost Performance Improvement, so that consumer acceptance is specifically tested and evaluated.

These changes in routine operating procedures are the highest priority for providers:

> Validate coverage and manage pre-authorizations. Patients cannot be left with costs by provider failure to ensure coverage for all services. Cases of an out-of-network anaesthesiologist, uncovered facility charges or inappropriate diagnosis code that cause claims denial are inexcusable. Providers in the new environment should have a customer service strategy that spans both the financial and clinical spectrum of care.
> Coach patients and physicians on medical decision-making. Health care systems should help providers cultivate the expertise to inform patients of benefits and risks, and provide the numbers for patients to make decisions. This will include provision of medical research results to which patients currently have limited access, rarely discussed in provider circles. Improvement activities can be structured around high risk patients that are likely to generate more costs, with shared decision-making as a measured intervention.
> Move forward on providing price transparency to consumers. Consumers need predictability. Providers can structure episodes of care with pricing, using cost data.
> Make medical records easier to access, including images. Patients frequently go through complicated processes and time to get their data, simply so that they can make decisions. Providers should be able to provide patients with standardized digital versions of chart history, images and transactions that the patients can use for second opinions.

Health care systems have grown from small hospitals into hospital-plus-physician enterprises, and from there into large networks. Consolidation has made bureaucracies harder to maneuver at a time when costs are rising. Health care providers that take care to assist patients are more likely to attract loyalty and also achieve better results in both outcomes and cost performance.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

Image Credit: Stephen Leonardi