Reining In Medical Costs Might Work If We Could All Agree What "Cost" Means

written by Theresa Hush | January 11, 2018

A few days ago, a couple of providers commented on my recent posts about cost performance improvement in health care. The first of these posts reviewed obstacles to provider strategies for managing costs and how to overcome them, and the second addressed technology that providers would need to both measure and improve performance. One commenter took issue with my statement that providers have not embraced cost reduction because the reimbursement system rewarded growth and more services. Another stated that providers have undertaken cost control for years, and they have invested heavily in accounting and financial systems, as well as aggregation of clinical and financial data with risk-assessed scores.

I appreciated these comments. They made me realize that, in our national conversation about affordable health care, conflicting definitions of cost is one factor that leads to a failed strategy for getting what we want. We don't, in fact, want the same thing.

Purchasers Target Population-based and Per-patient Costs

Throughout my professional career, I have dealt with rising health care costs in one way or another. My early years were spent directing employer benefit plans, then governmental and commercial health plans. I saw how health care costs dragged down state budgets for Medicaid and employee health care, and I saw how employers and health plans were powerless to change the results.

As an employer, my experience working with other large employers only reinforced how difficult it was to change health care from this sector of market. It was hard to get data and to understand what was driving our increasing costs. It was harder, yet, to negotiate reductions in employee benefit plans or to design care programs that promised to reduce costs.

My experience in state government, heading Medicaid, was similarly frustrating, despite the common belief in governmental control. Providers imagine that running Medicaid is a powerful job because, as for Medicare, one can simply decide what the program will pay and who will get it. In that make-believe world, coffers are flush—and when there's not enough money to go around, fraud must be rampant. In reality, the process of getting money for a state agency is a lot like competitive wrestling, a hard battle with lots of mudslinging, and routing that money is like running through a minefield. There are never enough funds to provide needed access for children and others who can't afford health care. The reason? Because the costs keeping going up, for everyone.

Providers Define Medical Costs in Accounting Terms

My perspective on medical costs was, thus, honed by purchasing decisions and policy-making, as I balanced the goal of providing access to care against money to pay for it. That perspective matters, as I later discovered when switching "sides" and entering the provider world. In that environment, medical costs were recast as revenues and the mission was to ensure their continued flow and viability. Cost control meant budget control over hiring and purchases, and managing the cost of supplies and facilities.

In my provider world, "costs" were exclusively understood in terms of how they affected the organization's budget and bottom line. Our negotiations of health plan rates for institutional and physician services reflected a market price for our scale and sophistication in the health care arena. That price was defined by the health plan's leverage vis-à-vis ours, with respect to our relative positions in the market. The essential point here is that those prices had nothing to do with costs per se, but, rather, with how much the health plan needed us and how much we needed their covered patients.

On the provider side of the market, there was no cost strategy to address the overall cost of

care, as purchasers envision. Instead, the struggle to manage costs was focused on living within the budget and available resources. That budget was derived from calculations of expense limits based on expected and historical volume of patients and services, and the payments by Medicare, Medicaid and commercial health plans for those services.

Building the provider budget in this way makes perfect sense, as does negotiating rates based on the market—for the survival and growth of the provider. The problem is that the provider's goal is (understandably) to always get more in an environment where (theoretically) we want to pay less. Calculating a budget based on how much the market will pay would produce a big Excel error as a circular reference.

It is true that providers have invested heavily in systems for accounting, finance and aggregation of clinical and financial data. But look at the purpose and output of those systems, and you will find that they are designed not to reach an understanding of the cost of care for a population or per patient, or to develop cost performance based on how purchasers view cost of care. Rather, they are designed to identify revenue potential, such as justifying risk for higher reimbursement or for reaching more patients to provide more services. These systems are growth tools, and while they could also be used to fuel cost performance in Value-Based Health Care, this is not a common use.

Consumers Focus on Cost of Coverage and the Mystery of Medical Pricing

Consumers are completely in the dark about the fact that "prices" in health care are a set by arrangement between health plans and providers, negotiated with commercial health plans and set by rules in government. These same arrangements also determine whether consumers are subject to balance billing by providers. To the consumer, the cost of health care is equal to what they pay in premiums to insurance carriers plus deductibles, copayments and non-covered charges.

Facing potential (and real) loss of coverage and the scaling back of benefits, consumers have begun to focus both on prices and medical costs as a reflection of those prices. This matters, because consumers are sharing a larger percentage of costs with their employers and, as a result, have birthed a political movement about access and the cost of health care—defined on their terms. As American mortality and morbidity rates increase, we can expect consumers' angst to grow and fuel increasing political pressure for change.

How a Common Definition of Medical Costs Would Benefit Everyone

If providers cannot understand what the market wants them to do, can they meet those

expectations and constrain the costs of care? Not really. Those providers, unless they are able to measure cost using a standard similar to purchasers', cannot identify their care issues and support improvement.

Value-Based Health Care is built upon cost measures that reflect the perspective of purchasers, not providers. While current reimbursement incentives may slow the process of reform, ultimately those measures—such as Medicare's MACRA MIPS cost scoring and commercial plans' shift of expenses to consumers and narrowing of provider networks—will force reform.

Making improvements in the cost of care will benefit consumers as well as improve the provider's relative cost profile for purchasers. Indeed, consumers are critical to the endeavor, and including consumers in the development of solutions to lowering cost is essential. Medical decision-making, for example, can incorporate understanding of cost and clinical outcomes for both providers and consumers, leading to better long-term results for patients.

Providers conceptually understand and agree to the concepts in Value-Based Health Care, and want to do well for their patients. They are gaining the expertise to better measure clinical results, but cost performance with respect to VBHC is still new territory for everyone. Moving in that direction, however, means fully appreciating how to begin measuring costs and cost drivers, and then constructing interventions to improve costs without sacrificing good patient results.

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: Kawtar Cherkaoui