Providers Should Believe in Health Care Cost Control Now—If They Want to Stay in Business

written by Theresa Hush | November 2, 2017

Despite MACRA and other Value-Based Health Care efforts, many health care providers believe that controlling health care costs is impossible to do. They cite lack of comprehensive data about their patients and where they obtain services, and lack of control of patients' decisions.

But the real issue that providers have with cost control is much simpler: Why give up revenues under Fee for Service by reducing volume of services? That system has rewarded them well, fueling the growth of consolidated health systems, technology expansion and purchase of physician practices by ensuring a patient base. Controlling costs is now a relatively low priority. Under Medicare MIPS, it has zero weight in scoring. In ACOs, there is only a minimal incentive. Patients in private health plans often still have choices beyond severely limited provider networks.

So what's the rush? The future of more narrow networks and financial risk might seem a long way off to providers focused only on the present.

Major Changes May Not Be Obvious, But Are Planned

The problem, of course, is that this strategy will rob providers of the precious time they need to manage some of the big changes coming — or here already — in health care economics. Consider some of these key trends:

A major shift to increasing the financial burden of consumers is underway. While this relieves pressure on employers and/or health plans, it increases bad debt for providers.

Benefit plans have higher deductibles and copayments every year, with many employers now opting for high deductible plans guaranteeing coverage only after $2,500-6,000 in expenses.

Medicare Supplement Plan F, the most popular Medicare supplement option, will expire for new enrollments after 2020. To save money and allow for higher physician fees, Congress decided that consumers should pay more in deductibles and copays.

Coverage is being limited and even disappearing. Some version of the ACA repeal will likely pass, and Medicaid will receive cuts. More people will have less money for health care.

Medicare and other payers are moving to financial risk, believe it or not! Even though this intent is spelled out in MACRA rules, the transition is likely to move at an even faster pace because of the push to decrease the regulatory burden on providers. Financial risk plans like Medicare Advantage are the logical replacement to MACRA and ACOs, with less government costs in administrative approvals, management of claims, and associated costs.

We will see growth of narrow networks of lower cost providers and benefit plans tied to small provider networks or employed providers, both of which will lower revenues for higher cost providers serving patients most at risk.

It's hard to imagine a scenario under which health care systems can continue their current level of profitability, given these trends. The providers that attract patients will reorient their services, marketing and value toward ensuring that consumers are protected from excessive costs and can make responsible decisions.

Health Care Systems Can Get the Cost Data They Need to Act

While the payer side of health care — including Medicare, Medicaid and most health plans — has robust data that reveal a comprehensive picture of each covered patient's expenses, providers are limited to data within their own systems. If the patient goes elsewhere, providers don't know. In fact, even within a system, it can be hard to aggregate cost data to provide a view of services utilization or leakage from the system.

The advent of Medicare and health-plan-provided data is changing that. Medicare data sets, such as the Quality Resource and Use Reports (QRUR), provide annual plus supplemental data that offer some excellent information for provider analysis, and some of that data is patient-identified. In particular, episodic cost data that provides detailed patient and services data can be a model for providers to construct their cost performance system.

What are the data types that could be of value to providers?

Identify Aggregate Costs, Per-patient Costs and Comparisons

Cost per Medicare beneficiary (CMS Quality Resource and Use Reports, or "QRUR")
Cost per covered individual, generated by primary care physician (health plans)
Costs per Episodes of Care/Procedure (QRUR, some health plans)
Comparative Medicare costs generated by attributed physician (QRUR)
Comparative costs generated by primary care physician (health plans)
Cost per covered individual, generated by primary care physician (health plans)
Comparable Medicaid cost data (State Medicaid programs)
Claims and reimbursements by episodes of care and by specialty/provider (provider source data)
Billed and reimbursed cost per inpatient, outpatient, ambulatory (provider source data)

Search for Excess Cost Drivers

Ambulatory Sensitive Admissions (QRUR)
Emergency, Diagnostic and Anaesthesia costs, aggregated and grouped by diagnosis/procedure (health plans)
Out-of-system referrals (health plans)
Diagnostic technology episodes by patient/diagnosis (provider source data)
Emergency visits by patient/diagnosis (provider source data)

Outbound referrals by physicians, by specialty/reason (provider source data)

These two groups of data create the baseline for the most important analyses of cost: overall cost of care by condition and procedure; leakage from the provider system to outside services (and why); generation of costs for technology and other key cost drivers.

Data Should Prompt Health Care Systems to Start Questioning

If the data are enough to identify areas where costs are high, many people outside the health care organization assume that this is enough to go after problem providers and areas of cost excess. This is naïve at best, and could be damaging to providers and patients.

The goal for addressing costs is to measure and then improve performance through an ongoing and evolving process. Measures of cost performance are key indicators, but they don't tell the full story. Data could be missing or incorrect, patients could have higher or lower risk, and different protocols with variability in services could be required for the patient's condition.

Relying solely on quality measure results to accurately represent quality at face value is inherently flawed; so is the use of cost measures as scores or benchmarks for care. There are hundreds of reasons why variation can and should occur. The task of determining why that variation occurs should be part of the feedback from clinicians. Higher cost in individual cases is often completely justifiable. High aggregate costs across all providers or individuals should raise questions. In both cases, further inspection is needed.

But Is Data Enough for Action?

It all depends on what "action" means. Improving cost performance is a complex process that will take more time than initial measurement. It should be both iterative and collaborative. The means or "interventions" for cost performance improvement are rarely clear-cut. Improving cost performance involves a process of targeting and testing interventions that have potential for cost reduction, and exploring how and why that reduction can be achieved through a measured improvement project.

Action is difficult not because of resistance; rather, this is due to lack of knowledge. For example, reducing the cost of excess radiology through multiple serial procedures sounds reasonable, but the contribution of each procedure to the final diagnosis or treatment is not always understood until retrospectively reviewed. The review of such data is new to physicians and relevant to how they make future clinical decisions. Reviewing cases of patients is likely to

result in physician adjustment, due both to Hawthorne effect and physician learning. But only through measuring impact of the case review intervention can we tell exactly how effective that process will be and whether results will diminish over time.

Cost Is an Outcome; Innovation and Time Are Essential for Success

Excessive costs are an outcome, and that outcome is often shared by both physician(s) and patient. Failure can come from either or both parties.

One goal of cost performance measurement, therefore, is to identify the point at which an outcome has become a failure and create interventions to avoid it in the future. Time and an environment of collaboration — not punishment — are essential for this effort to succeed.

Ultimately, the most innovative cost performance strategies will address how providers and patients share information, and will generate effective means to help patients understand treatment alternatives and how to choose wisely. That effort will require both performance improvement technology as well as an organizational shift to refocus priorities toward meeting needs of patients over providers.

The message to health care systems that are banking on time to achieve more growth in size and revenues before addressing cost performance: time is not on your side. Even after investing in a significant, lengthy effort to obtain and analyze data, providers must be prepared for the reality that developing initiatives and allowing for participants' learning curves will take years, not months. To remain viable for the long run, begin efforts now to improve cost.

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.

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