3 Essentials to Cut Health Care Costs Without Cutting Patient Care

written by Theresa Hush | March 6, 2025



There is an understandable fear and a little outrage right now about health care budget cuts. Some proposed cuts will raise the amount of unfunded care for hospitals and physicians if Medicaid coverage is reduced, and impact patients in nursing homes. Other proposals will eliminate offsets for medical debt or physician education through residency programs. While not directly affecting Medicare benefits, these proposals affect the bottom line of hospitals and health systems, and all patients and coverage programs will bear the brunt.

Providers’ lack of engagement in cost control must change. While the industry claims to be experts about health care and its costs, the slow adoption of risk payment models in Value-Based Care has precipitated a crisis in costs that requires immediate correction. The only way to change it is for

providers to get out in front on cost control.

A “Scarcity” Approach to Cutting Health Care Costs

Traditional approaches to trimming health care costs involve a mix of cutting patient services while expanding revenues. Prior authorization denies patients coverage for services advised by their physicians. Take the trend of cutting obstetrical services, which has become a common approach to cost management that leaves patients without access to necessary care.

A charge for asking your doctor a clinical question on the EHR portal expands revenue, but it also limits patient engagement that was once seen as positive. So too, concierge fees for faster access to your doctor increase revenues to avoid cutting patient care, but limit who can afford to be seen.

These are Scarcity approaches to health care cuts. While we know that health care costs are out of control, these are not the best strategies for managing costs. They do nothing to improve the real value of health care. Over time, Scarcity approaches diminish not only your contribution to health care, but also your most precious resource—your patients’ trust.

If this mindset prevails, health care could go the direction of airline travel, where even choosing airplane seats requires calibrating the benefits of additional foot room with the price of travel. Is that really what we want?

3 Ways an “Abundance” Approach Will Achieve Value Without Reducing Services

Instead, we can approach health care cost control with an Abundance mindset. Abundance is the route of Value-Based Care. Overall cost—and revenues—are constrained by payment models. We do more with less by allocating services according to a “top of license” approach, directing resources toward the highest risk patients, engaging patients in care for better outcomes, deploying technology for value, and solving problems before they occur.

Let’s examine how to control costs within the Abundance context. To better manage or even reduce resources, you need to deploy strategies to initiate change in the relationships between key parties: clinicians and their patients and support system, and the information flow between them.

But you can’t create strategies that achieve cost control and better value unless you have alignment with your patients’ expectations of what they *should* get from you. In other words, you can’t control costs if you and your patients are not in a trusting relationship. Any cost initiative will fail if you have not taken care of these three essentials:

1. Implement clinical teams led by physicians, other clinicians, and personnel to support complex patient care.

Without support, physicians end up without the resources to improve outcomes and prevent utilization events under value-based payment models. While many ACOs and health systems have separate support systems in population health and utilization management, these often do not work in concert with clinicians, leaving the physician to bear the burden of failure in a fragmented system. Patients and their support partners need to understand who is in charge and how to engage with them.

With a clinical team approach, individual functions are delegated to team members to support the physician-patient relationship and treatment plan. These include contact with the patient, determination of patient needs for more intensive communication, preparation of patient information, preparation of patient self-management programs and enrollment of patients, specialty referral follow-up, monitoring of patient clinical status, patient decision-making materials, and treatment cost information. None of these functions can be reasonably performed by physicians if we are trying to ensure a “top of license” approach that ensures that the clinician focuses on medical needs, and the supporting members of the team engage in the matters that feed into the pool of information and decisions.

2. Prioritize two areas of cost control: chronically ill, high-risk patients, and specialty care.

There will always be unanticipated costs and patients in

trauma. If you have developed a clinical team approach, these will be handled within that context. But the greatest pounding on costs inevitably builds from two pressure points: patients with chronic disease, especially those whose conditions are not well controlled, and specialty care services. There is overlap between these two, but each will require strategies.

Lowering costs can only be achieved by creating systems through a combination of data and initiatives. In the interests of reducing costs enough to meet your bottom line, it makes sense to go after the largest patient populations and/or largest dollar services. Your goal is not to eliminate these services (the Scarcity approach) but to improve outcomes at lower cost (the Abundance approach). For instance, you can target patients with chronic illness and behavioral health issues, which have higher emergency and inpatient admissions, to proactively reduce chance of complications. You can create a risk-centric pool of patients with multiple conditions, exacerbations, and prior utilization to help pinpoint those who need attention, to ward off an expensive crisis (in every sense of the word).

For specialty services, you will almost certainly need to target your major referred groups, if you are a primary care practice. These will usually include Orthopedics/Neurosurgery, Cardiology, and Oncology. Your goal is much the same: improve the per-case cost by avoiding complications and “redo’s” and collaborate with specialists on complex medical management and shared decision-making.

3. Align your patient care with patients' expressed needs.

Part of the "cost" of doing health care includes missed opportunity with patients. You might call it a lack of "patient compliance", but the issue is much bigger. It can include wavering trust in you, lack of information about the benefits or harms of treatment, challenging financial or other patient circumstances, health care literacy, not enough time. Better communication is essential to traverse this territory. Members of the clinical team can carry the weight of this effort, with training, inclusion in patient care, compassionate listening, and consistent messaging.

Patients say they want price transparency, honesty, and information. They want access to care when they need it and clear answers to their questions. They don't want to hide their own concerns and circumstances—but they may be inclined to, if they don't feel heard or respected in a conversation.

In short, you can't "do" cost control without establishing and maintaining a trusting relationship with patients, to increase the odds that they call you before going to the emergency room or ask for your guidance before making a decision with a specialist.

To use a positive airlines analogy, cost control in Value-Based Care starts with a familiar line heard on every flight: "We understand you have a choice, and we want to thank you for flying with us today."

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