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Accounting For Costs, Improving Care

In an industry long wedded to fee-for-service payment structures, understanding the true cost of care of an episode has been a rarity

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The financing of healthcare is moving away from volume and toward value. Providers of all stripes will increasingly be compensated not on how much they do, but rather on how well they do it, and what outcomes they produce.

Among other things, this transformational model of care is driving the huge spate of physician acquisitions by health systems. For the latter, managing cost—still largely driven by physicians—will be the hallmark of success, and industry performance will be more closely scrutinized than ever before. Healthcare's portion of the GDP, now at approximately 18 percent, is heading upward, and reports suggest that as much as 30 percent of these dollars are spent needlessly.

The Affordable Care Act may ultimately expand the insurance pool substantially, and more people will move through the hospital doors for care. But, as a result of the push towards accountable care, increased census no longer translates to higher revenue for hospitals. Unless costs are managed internally, higher patient volume may instead lead to narrower margins, if not outright red ink.

At-risk payment structures

Consider Medicare's bundled payment model—which is in the early stages of implementation and looking to expand. In this model, providers would be paid a universal fee to cover all aspects of a procedure, from pre-planning testing to post-discharge therapy. In the case of hip replacements, for example, that might entail lab work-ups, surgical expenses and post-discharge rehab. This means standardizing treatment on the best protocols and avoiding needless complications and readmissions. In other words, it means managing cost.

Bundled payments are just one of many at-risk payment structures under development by both public and private payers. But in an industry long wedded to fee-for-service payment structures and few financial penalties for wasteful, ineffective care, understanding the true cost of care of an episode across the multiple settings into which patients venture has been a rarity, not the norm.

A cost accounting approach

One health system that has tried to do so is Mission Health, a 5-hospital system based in North Carolina. Until recently, only Mission's flagship hospital had any kind of cost accounting system in place. "You would think [cost accounting] would be a core competency for any business, but small rural hospitals are there for the community first," said Larry Hill, Mission's vice president of finance. "As far as real performance detail goes, it is invisible."

Mission has deployed a standardized cost accounting system across its far-flung facilities. When Hill describes the system, he sounds like a chief medical officer describing the virtue of an integrated EHR—only for finance. The cost accounting tool will accept data feeds from various clinical, supply chain and billing systems, providing an analytics overlay that shows how aggregate patient level data informs service line performance. "Cost accounting shows how much we charge and how much it costs us to treat the patients," Hill said.

The cost accounting system works in conjunction with other modules in the financial planning life-cycle, including budgeting, long-range forecasting and contracts modeling. In short, Hill wants to build out a dashboard-accessible financial planning tool in which local hospitals can set budgets, track performance, monitor physician and other cost drivers, and apply that data to proposed payer contracts down the line.

Hill expects these payer contracts to increasingly be wrapped in pay-for-performance measures. Such an integrated financial planning platform may become as important to the fiscal health of a care delivery organization as an integrated EHR is to its clinical performance.

One of Hill's first projects involves modeling physician performance. The health system has some 250 employed physicians, whose compensation is based on work RVUs, a standard of physician output that weights the complexity of various tasks. Using a dashboard, Mission will present to physicians data revealing how their book of business performed against budget and what the variables are.

Hill said the tool will contrast across facilities revenue generated by physician activity, associated costs and overall clinic performance. "If there is more transparency, physicians can understand how they affect cost," he noted.

Hill is optimistic that a service line orientation—in which local departments can see how they are performing versus their peers in other facilities, and when appropriate, adjust operations accordingly—will catch on across Mission Health. "We are rolling out these tools across the health system," Hill says. "We can't get data fast enough. There is such a thirst for it. As we look at managing populations, we can better know who the population is at each facility and what that looks like financially."

This is the first article in a two-part series.