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# The 4 Biggest Cost Accounting Mistakes You Don't Know You're Making

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If healthcare providers share a common priority, it is cost reduction.

A 2013 HIMSS survey bears this out, with cost reduction cited as the highest priority among U.S. healthcare systems. That's no surprise, given the rapid emergence of fee-for-value payment models. These models require management not only of service line margins but patient outcomes as well. However, the industry is just beginning to appreciate the enormity of the task.

Advanced cost accounting is not just a new process or strategy but rather entails what many providers consider to be an entirely new mindset around the relationship between clinical performance and financial performance. Advanced cost accounting software and systems can help — indeed are a must — but without new ways of thinking, the effort to contain cost can easily flounder.

Here are four common mistakes I have encountered during my work implementing cost accounting systems with more than 200 healthcare delivery organizations. These are not the kind of inadvertent mistakes we all make, such as forgetting to attach a document to an e-mail. Rather, they more broadly reflect the ingrained work habits of the fee-for-service era and the corresponding management and systems structure that often supported it. I offer this list in hopes of stimulating new thinking around one overarching goal: better understanding and managing cost for the entire industry.

**Mistake No. 1: Cost data is not accurate**

During a recent webcast on this topic, I polled the audience as to which of eight common costing methodologies they were using. Not surprisingly, several of the methods — such as RVU based accounting and ratio of cost to charge — are among the preferred tools. Some of the 600 providers in the audience were even using such more time-consuming methods, such as time-driven activity-based costing.

Here's the bad news: Each of these methods can be useful on its own for limited purposes, but sophisticated cost accounting cannot rest solely on one methodology. Effective cost accounting must be a mix of all different methodologies depending on the situation and availability of data. For instance, costing of supplies using RVU or RCC will only provide an average cost and will be inadequate to understand variation as it relates to choices made per patient. Instead a patient-level markup or patient-level cost data must be leveraged.

When performed correctly, cost accounting can shed more light on a payer contract offering say, a slight premium above the Medicare rate for a certain procedure. What at first glance appears to be a profitable contract becomes more dubious as additional information is added to the analysis. The ability to negotiate more favorable payer contracts is just one benefit of avoiding this all too common mistake.

**Mistake No. 2: Cost data is too limited in scope**

Health systems invariably focus on hospital costs, often ignoring what is happening in their physician clinics, home health agencies and ancillary settings. It's an incomplete picture at best, and a misleading one at worst. In the era of bundled payment, tracking a patient's entire cost of care across the spectrum of the hospital departments and professional service settings will be obligatory. Service line profitability will become a measure not only for the local hospital department, but of the direct and indirect costs associated with professional services as well. Enterprise profitability across the health system, now understood in only the most

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generic terms, will be revealed in far greater detail. If you avoid this mistake, and broaden your financial perspective, your analytical capabilities grow in tandem. Comparing cost per case among physicians, for example, or understanding the labor requirements for a given population of patients, is now possible.

**Mistake No. 3: Cost data is inaccessible**

Here is my mantra when it comes to sharing cost data: Cost data is only as meaningful as the number of people with access to it. In many legacy cost accounting systems, getting access to cost reports often entails a) putting in a request to I.T. to run a report; b) waiting days for the report; c) figuring out that the delivered report should have included another variable; d) returning to step A.

Advanced cost accounting creates an infrastructure that enables self-service for financial analysts, department leaders and physician executives alike. At some delivery systems, such as Fairview Health Services, based in Minneapolis, this approach is blossoming. In stark contrast to its legacy approach, Fairview now grants more than 150 analysts immediate, 24/7 access to its cost accounting system. It blends data from the EHR, general ledger, physician practice management and enterprise resource planning systems. Before Fairview revamped its approach to cost accounting, the health system had only two data administrators with direct access and report writing capability.

The expansion of the user community — a move predicated on a robust training and education requirement on how to use the data — has helped reinforce the idea that cost accountability is everyone's business. Give people data and their ability to identify ways to manage costs flourishes.

**Mistake No. 4: Cost data is not actionable**

Probably the biggest impediment to cost reduction is cultural. While most health systems have cost reduction projects underway, only a minority of them actually hits their target. A Strata Decision Survey found that 88 percent of organizations have cost reduction targets but only 17 percent are meeting those goals. Our survey also revealed that difficulties in tracking savings, in managing projects, and establishing accountability often figure.

To counter that, I encourage promotion of "data discovery," namely enabling department leaders to write their own reports, conduct their own analyses, work with their own medical staffs and create transparency around their own performance. Cost accounting need not be the domain of cost-accounting "experts."

Making data actionable, however, requires far more than merely having a sophisticated tool set that integrates data from multiple sources. It all but demands new skills — skills such as adopting the sometimes arcane vocabulary of health finance. A new mind set is also called for. This means the willingness to adjust staffing levels to patient volumes, streamline management decision-making and address high-cost (and unnecessary) variations in care.

If you trust your end-users and give them the right education, support and tools, their ability to tackle these tasks might surprise you.

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