

Healthcare Cost Containment



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Using Cost-Accounting Systems to Prepare for Value-Based Care

By Dan Michelson

Health systems are capitalizing on their cost-accounting systems to reduce practice variation, tackle strategic initiatives, and break even on Medicare.

In an industry long wedded to fee-for-service payment structures, understanding the true cost of an episode of care across multiple settings is rare. However, several organizations are tapping into their cost-accounting systems to discern the total cost of care and prepare for a future defined by value-based payment.

Modeling Physician Performance

Until recently, only the flagship hospital at Mission Health, a five-hospital health system based in Asheville, N.C., had a 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,” says Larry Hill, vice president of finance. “As far as real performance detail goes, it is invisible.”

To get a better handle on its performance, Mission is in the early stages of deploying a standardized cost-accounting system across its facilities. The new system will accept data feeds from various clinical, supply chain, and billing systems, and provide analytics that show how aggregate patient-level costs affect service line performance. Hill’s goal is to build a dashboard-accessible financial planning tool in which local hospitals can set budgets, track performance, monitor physician cost drivers, and apply those data to proposed payer contracts down the line—contracts that will likely include more pay-for-performance measures.

One of Hill’s first projects involves modeling physician performance. The health system has approximately 250 employed physicians whose compensation is based on work relative value units (RVUs), a standard of physician output that weighs the complexity of various tasks. Using a dashboard, Mission will present physicians with data on revenue generated by physician activity, associated costs, and overall clinic performance across facilities. “If there is

more transparency, physicians can understand how they affect cost,” Hill says.

The finance executive is optimistic that a service line orientation—in which local departments can see how they are performing versus their peers in other facilities and adjust operations when needed—will catch on across Mission Health. “We can’t get data fast enough. There is such a thirst for it,” Hill says. “As we look at managing populations, we can better know who the population is at each facility and what that looks like financially.”

Helping Staff Be Strategic

Leaders at Legacy Health, a five-hospital, 1,500-bed delivery system in Portland, Ore., know firsthand that analyzing the financial health of various service lines is a complicated undertaking. For one thing, it requires freeing up finance department staff from the tedious task of generating reports off legacy systems. For years, Legacy Health relied on a cumbersome system to produce reports of often dubious value, says Ben Shah, information systems director of enterprise systems and services. “We were just running numbers, not adding value,” Shah says. “We were running more than 200 reports, many with the same data.”

Shah spearheaded an effort to streamline the operation, not only discarding needless reports but also creating a dashboard where department leaders could parse their own financial summaries. Now the dashboard includes standard metrics such as discharges, service line percentages of volume and margin, revenue by payer, and revenue and labor benchmarks such as charity care and paid FTEs. Executives retrieve data electronically instead of combing through paper packets associated with legacy reports. Automating the reports has freed up considerable staff time. “We have reduced the number of FTEs working on financial decision-support projects

from eight to five,” Shah says. “Now these employees are involved with other strategic initiatives that are helping us move forward.”

For example, Shah recently completed a major analysis of a wide variance in operating room (OR) supply costs. Costs had spiked, but increased volume was not the cause. Using analytics tools in the cost-accounting system, Shah’s team undertook an in-depth analysis of OR performance, looking at payer mix, types of surgery, patient mix, and service site. The group analyzed ORs by location and took into account many of the variables that drive costs, including physicians, patient diagnoses, and complications. Shah’s team eventually identified one physician who was a cost outlier because he was performing certain procedures in the cath lab, rather than the standard OR suite, where costs and personnel were lower.

That sole physician did not account for the entire spike in OR costs, but Shah says the exercise was useful in identifying how even one provider can cause a disproportionate rise. Shah’s group later analyzed the use of implants and determined that newer physicians were coming on board and using more expensive implants. As a result, Legacy was able to shift its purchasing strategy and narrow its implants to a standard list to secure better pricing from vendors.

Legacy also is using cost-accounting data to promote financial stewardship among its physicians. In the works is a “cost accounting 101” class targeting hospitalists. As part of the effort, the health system will provide data showing how hospitalist decisions ultimately drive the cost equation. “We can show how their costs vary from each other, including tests, imaging services, and lab work,” Shah says. “For example, do hospitalists really need to do a blood draw every hour? We can show the impact of those decisions, and then the hospitalists can look at the data from a clinical angle and challenge each other. We want to make sure what we are ordering is appropriate and we are not charging patients for things they don’t need.”

Of course, merely reducing expenses is not enough in the value-based care era, with many payer programs requiring providers to hit

quality targets to qualify for shared savings or pay-for-performance bonuses. This dynamic underscores why leaders such as Shah use the cost-accounting data as a starting point for discussions with the medical staff. Any changes in medical protocols are driven by physicians, not finance executives. “My job is to analyze,” he says. “The data get us to that point, but then we turn it over to the clinical leadership.”

Breaking Even on Medicare

Health systems with large Medicare populations face some of the greatest financial challenges under healthcare reform. One example is Parrish Medical Center, a 250-bed acute care hospital in Titusville, Fla., where approximately 55 percent of patients are insured by Medicare, says Mike Sitowitz, controller.

Parrish is embarking on a “Medicare break-even” analysis that the controller hopes will shine a light on previously obscure areas of operation. The hospital is analyzing the profitability of four main service lines—cardiology, neurosciences, orthopedics, and pulmonology—under Medicare.

Using a cost-accounting system, Sitowitz can drill down to the patient level to spot variations in treatment. Because the hospital has standard protocols and clinical pathways for treating certain ailments, the cost-accounting system offers insight into instances when care varies from the path—instances that represent an opportunity to reduce waste and cut costs. The setup includes dashboards tailored to teams of physicians, who can compare themselves to their peers and see how they are working to help cut costs.

Sitowitz envisions turning over the dashboards to service line leaders, who can make inferences for the future using the cost-accounting data and the system’s forecasting tools. “We will need to operate with less reimbursement and get our costs in line,” says Sitowitz, offering a pithy summation of the industry’s future—and of why cost accounting is here to stay.

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