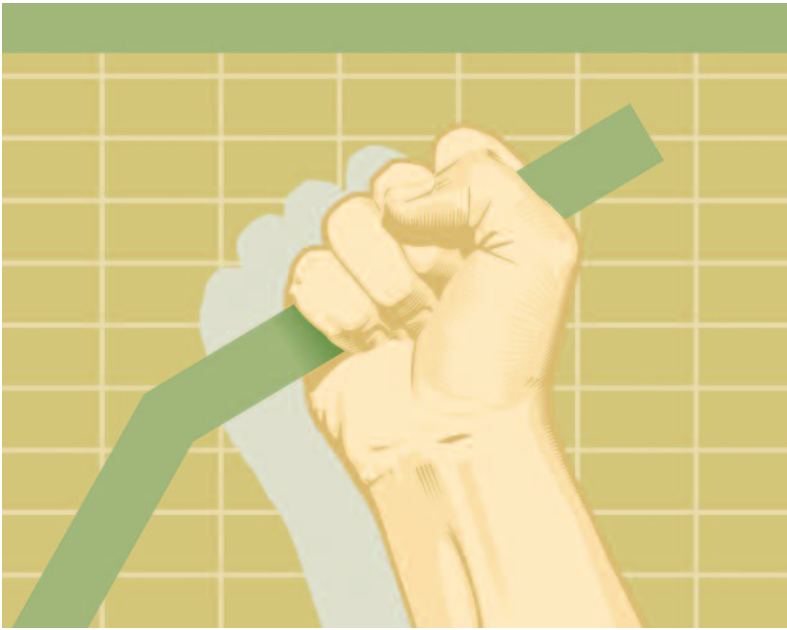


FEATURE STORY

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the healthcare cost curve *can* be bent

It may be possible to check the steep rise in our nation's healthcare costs, but to do so quickly and effectively will require a concerted effort by all stakeholders to tackle the primary drivers of those high costs.

Few national issues are as important as the need to bend the healthcare cost curve to gain control of the spiraling costs of U.S. health care, especially for Medicare. This topic has been researched and discussed for years. Now, based on the findings of recent research into the potential impact of accountable care organizations (ACOs) and the movement toward value-based payment, it seems quite possible to bend the cost curve downward.^a

a. We examined the impact of ACOs in a 2010 study sponsored by the American Hospital Association; our research regarding the transition to value-based payment was sponsored by HFMA as part of the Association's ongoing Value Project.

In presentations on factors driving healthcare costs, we often list 25 factors (shown in the sidebar on page 2) to kick off discussion. The list is based on what others have written or said is the *single* most important factor driving costs upward. We ask the members of our audience to tell us which factor they think is most important.

The responses tend to vary widely. Our view is that multiple strategies must attack different aspects of cost savings at the same time. In Boston, for example, Partners HealthCare is addressing 20 different aspects of cost reduction simultaneously—including chronic disease, care access, IT enhancements, patient engagement, end-of-life care, and incentive structures. Communities and health systems are likely to disagree about which ways are best for bending the curve. However, multiple approaches will be required to deal with accelerating costs.

Factors Having the Greatest Impact on Healthcare Costs

1. Aging of the population
2. Advances in medical technology
3. Inappropriate and unnecessary care
4. The fee-for-service payment model
5. Not enough primary care providers
6. Inconsistent management of patients with chronic conditions
7. Defensive medicine/medical malpractice
8. Slow application of clinical IT
9. Fragmentation of care (e.g., “focused factories” owned by specialists)
10. Management of outpatient costs
11. Lack of care coordination
12. Direct-to-consumer marketing of drugs
13. Cultural inertia and unwillingness to change
14. Unrealistic patient expectations
15. Complexity and high overhead
16. Cost shifting
17. Insurance industry profits
18. Hospital capital investment and high staffing levels
19. High incomes of medical specialists
20. Ineffective roles of patients and employers in affecting costs
21. Uneven access to care
22. Poor quality of care
23. Obesity
24. Fraud and abuse
25. End-of-life processes

Source: McManis Consulting.

AT A GLANCE

The nation’s annual growth rate of medical costs could be halved if the nation were to rigorously pursue the following initiatives, among others:

- > Move rapidly from fee-for-service to value-based contracting.
- > Increase the supply and effective utilization of primary care physicians and physician extenders.
- > Focus more on chronic disease management.
- > Pass tort reform.
- > Encourage the formation of multispecialty group practices and integrated systems.
- > Reduce administrative complexity.

Potential for Bending the Cost Curve

A commonly cited belief among industry analysts is that 30 percent of all healthcare spending is inappropriate or unnecessary—that it is essentially waste. This view appears to be well founded. The findings of four industry research entities buttress this opinion.

Truven Health Analytics. In a 2009 white paper, Truven (then Thomson Reuters) explored the question of how waste costing \$700 billion per year (2006 dollars, or 30 percent of total spending) could be taken out of the U. S. healthcare system. *Waste* is defined as “healthcare spending that can be eliminated without reducing the quality of care.”^b

Thomson Reuters identified six categories of waste and estimated the annual dollar impact for each one:

- > Administrative system inefficiencies (\$100 billion to \$150 billion)
- > Provider inefficiency and error (\$75 billion to \$100 billion)
- > Lack of care coordination (\$25 billion to \$50 billion)

- > Unwarranted use (\$250 billion to \$325 billion)
- > Preventable conditions and avoidable care (\$25 billion to \$50 billion)
- > Fraud and abuse (\$125 billion to \$175 billion)

Dartmouth Atlas of Health Care. Researchers at the Dartmouth Institute for Health Policy and Clinical Practice point to unexplained geographic variation in healthcare costs. Most notably, Dartmouth researchers John E. Wennberg, MD, and Elliot S. Fisher, MD—working with their associates to mine the Medicare database, and taking pains to adjust all comparisons to reflect the age and health status of the local Medicare population—have consistently found large variations in the amount spent for specific procedures in various small areas of the country.^c

Analysis of geographic variation is important to understanding the potential to bend the cost curve because it provides insight into physician-induced demand. For example, a 2011 article for HealthLeaders Media reported the following findings of Dartmouth research:^d

c. The published findings can be accessed at the Dartmouth Atlas website (www.dartmouthatlas.org).

d. Commins, J., “Dartmouth Atlas Finds Vast Regional Differences in Medicare-Backed Elective Surgery Rates,” HealthLeaders Media, Feb. 24, 2011.

b. Kelly, R., *Where Can \$700 Billion in Waste Be Cut Annually from the U.S. Healthcare System?*, October 2009.

- > Men older than 65 with early-stage prostate cancer are 12 times more likely to have a prostatectomy in San Luis Obispo, Calif., than they are in Albany, Ga.
- > Medicare patients with heart disease are 10 times more likely to undergo a procedure such as angioplasty or stent insertion in Elyria, Ohio, than they are in Honolulu.
- > Women older than 65 are seven times more likely to undergo a mastectomy for early-stage breast cancer in Victoria, Texas, than they are in Muncie, Ind.
- > Medicare patients are almost six times more likely to have back surgery in Casper, Wyo., than they are in the Bronx, N.Y.

Atul Gawande, MD, emphasized the importance of studying regional variations in his widely read article “The Cost Conundrum,” published in *The New Yorker* in June 2009. Gawande, a surgeon at Brigham and Women’s Hospital in Boston, compared the medical communities in McAllen and El Paso, Texas. Gawande based his discussion on Dartmouth data indicating that, in 2006, McAllen, one of the poorest counties in the country, had the highest Medicare costs per capita in the United States and was experiencing the most rapid growth in costs.

Costs in McAllen were twice as high as those in El Paso, 700 miles up the road and also on the border with Mexico. Hospitals in El Paso had almost the same levels of medical technology, and their quality ratings were comparable. Gawande underscores the variation in physician practices: “Between 2001 and 2005, critically ill Medicare patients received almost 50 percent more specialist visits in McAllen than in El Paso, and were two-thirds more likely to see 10 or more specialists in a six-month period.”

McKinsey Global Institute. McKinsey has issued three major studies on this issue. In its latest study, based on 2006 data, McKinsey estimated that the United States spent almost \$2.1 trillion on health care in that year—nearly \$650 billion more than the nation would expect based on data from 13 peer countries compiled by the

Organisation for Economic Co-operation and Development.^e There is no evidence that patterns have changed over the past six years.

According to McKinsey, the biggest difference—\$436 billion per year (two-thirds of total discrepancy between the United States and other developed countries)—is in outpatient services, which include physician office visits, same-day visits to hospitals or their emergency departments (EDs), ambulatory surgery centers (ASCs), diagnostic imaging centers, and other same-day facilities. Outpatient services not only account for most of the differences, but also constitute the fastest growing component of costs in the U.S. healthcare system. The report states, “More than is the case in any other country, the United States has effectively moved care from an inpatient setting to an outpatient setting.” Anyone working in health care recognizes that this statement is true.

Institute of Medicine (IOM). The highly respected IOM finds that the U.S. system squanders 30 cents of every dollar spent on health care. In a recent report, the IOM finds that the nation’s healthcare system wasted an estimated \$750 billion annually.^f

The research of these four organizations clearly supports the claim that at least 30 percent of all U.S. healthcare spending is wasted. It also seems clear that a significant portion of the excessive healthcare spending in the United States is in the outpatient arena, where the main driver is profit opportunities in performing certain diagnostic tests and surgical procedures. We need only point to our research findings regarding spine surgeries performed in Rapid City, S.D.; Casper, Wyo.; and Oklahoma City: We did not see a single neurosurgeon practicing in these communities who is earning less than \$1 million a year. In all three communities, neurosurgeons own all or a large share of the surgical hospitals where they perform

e. Farrell, D., et al., *Accounting for the Cost of Health Care in the United States*, McKinsey Global Institute, December 2008.

f. *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, Institute of Medicine, September 2012.

spine surgeries, and spine surgery rates per capita in these communities are substantially above national averages.

What to Target?

Where should the nation concentrate its efforts to reduce the high costs and waste in its healthcare system? For a number of reasons, it seems likely the greatest impact on bending the cost curve can be achieved through a focus on 10 of the 25 factors listed in the sidebar on page 79:

- > The fee-for-service payment model
- > Insufficient numbers of primary care providers
- > Inconsistent management of patients with chronic conditions
- > Defensive medicine and medical malpractice
- > Fragmentation of care (e.g., “focused factories” owned by specialists)
- > Management of outpatient costs
- > Complexity and high overhead
- > Cost shifting
- > Ineffective roles of patients and employers in affecting costs
- > End-of-life processes

Although the importance of the other 15 should not be understated, there are compelling reasons for focusing on these 10 factors.

For example, it may seem counterintuitive to regard fragmentation of care and management of outpatient costs as two of the top drivers of costs, given that most ASCs are less expensive than an overnight stay in a hospital, and they typically deliver high-quality care. But as the McKinsey Global Institute notes, this category (which includes hospital ED visits) accounts for two-thirds of the difference between U.S. healthcare costs and those in other developed countries, and is also a major reason that U.S. costs are growing rapidly. The reality is that an increasing proportion of our total costs are being absorbed in outpatient settings, with relatively little attention paid to how outpatient services are organized to achieve maximum efficiency and quality.

Consider, also, the problem of inconsistent identification and management of those with chronic

disease. That fact that newly formed ACOs are intent on tackling this issue underscores its importance in driving costs. These organizations are going where the money is: There are big dollars being spent on those with chronic disease, and there are promising opportunities to apply clinical information systems, computerized analysis of claims data, enhanced care coordination at the primary care practice level, and improved post-acute care to reduce these costs.

The shortage of primary care physicians is a national disgrace for which we are paying dearly. This shortage is due, in large part, to a lower earning potential and less attractive lifestyle associated with primary care as compared with specialty care. Experiments involving the use of EHRs and secure online messaging—such as those explored by Oakland, Calif.-based Kaiser Permanente and Seattle-based Group Health Cooperative—suggest that technology, financial incentives, and creation of chronic care teams may be a major part of the solution.⁸ This problem must be dealt with aggressively if we hope to bend the cost curve.

Examples of Cost-Cutting

Many organizations are already substantially reducing costs and bending the cost curve. This assertion has been corroborated in the findings of four cases studies we performed for the American Hospital Association in 2010 (www.aha.org/acocasestudies) and in the results of 10 site visits performed more recently as part of research for HFMA’s Value Project (www.hfma.org/valuejourney).

For example, one of the four AHA case-study organizations is New West Physicians, a medical group composed of 85 primary care providers located in the Denver area. We found that New West is delivering primary and specialty care to a

g. Chen, C., Garrido, T., Chock, D., Okawa, G., and Liang, L., “The Kaiser Permanente Electronic Health Record: Transforming and Streamlining Modalities of Care,” *Health Affairs*, March/April 2009; and Vijayaraghavan, V., and Beasley, G., *Group Health Cooperative: A Case Study Series on Disruptive Innovations Within Integrated Health Systems*, Innosight Institute, February 2011.

large panel of Medicare Advantage enrollees for substantially less than traditional Medicare would pay.

Another AHA case study, Memorial Hermann, a large multihospital system in Houston, has experimented with groups of uninsured patients to attempt to reduce their utilization of hospital services. In the year before enrolling in Memorial Hermann's Community Outreach for Personal Empowerment program, 600 patients had visited the ED 2,165 times, but in the year after enrolling in the program, their visits dropped to 1,291. Similarly, inpatient visits, which numbered 756 in the year before enrollment, dropped to 391 in the year after enrollment. Savings for these patients amounted to \$3.6 million over two years.

A second Memorial Hermann pilot program saw the voluntary enrollment of 540 Medicare patients. These patients had accounted for 419 ED visits in the year prior to enrollment, but ED visits actually increased slightly in the year after enrollment, to 467. The program was more successful in its first year in reducing inpatient visits from 2,180 prior to the program to 1,468 after the program kicked in. Total savings amounted to \$6.5 million over two years.

Geisinger Health System in Danville, Pa., one of the HFMA site visits, is actively pursuing several initiatives to reduce costs—including bundled-payment (ProvenCare) approaches for numerous services, such as orthopedics and cardiology.

10 Initiatives to Bend the Curve

So what are the most promising strategies for bending both the total healthcare and Medicare cost curves? Here are 10 proposals for initiatives that have the potential to halve the annual growth rate of medical costs.

Move with deliberate speed from fee-for-service to value-based contracting. Medicare, private health plans, and employers should aggressively move away from open-ended, fee-for-service contracts

toward payment based on value. Payers recognize that the pace and path of change will vary based on local conditions. Meanwhile, leaders of hospitals, health systems, and physician groups should be more aggressive and creative in preparing to succeed under value-based payment and in approaching customers with new payment models. The Affordable Care Act (ACA) encourages changes in the payment methodology, but a greater sense of urgency is needed by all sides.

Health systems and physician groups have to judge where their "tipping point" is—where they are receiving sufficient value-based (as opposed to fee-for-service) payments to warrant reengineering their approaches to care. Payers and providers must work hand-in-hand for this transition to work.

Even though healthcare systems and markets may move at different speeds, all have to move more quickly if the cost curve is to be bent downward. For example, the transition requires faster movement among physician groups and health systems in adopting new management dashboards, analytics, and other business intelligence, and in creating workable ACOs and similar organizations capable of managing the health costs of a population. Payers also will need to contribute by rapidly increasing incentives (e.g., covering more up-front costs of

Organizational Road Maps to Value

The authors of this article recognize differences among various types of healthcare systems and markets in their journey toward improving value, but note that all organizations will have to move faster to close the value gap by improving quality of care while reducing total cost of care. In Phase 2 of its Value Project, HFMA has defined road maps to value for different types of hospitals and health systems, including:

- > Academic medical centers
- > Aligned integrated systems
- > Multihospital systems
- > Rural hospitals
- > Stand-alone hospitals

Road maps for each of these organizational types, as well as a common road map to value, are available at hfma.org/valuejourney.

nurse care coordinators) and the differential between the amounts providers can receive from value-based payments versus fee-for-service.

Increase the supply and effective utilization of primary care physicians and physician extenders. The ACA established five initiatives to promote primary care, but more are needed—and fast. The success of accountable care depends on primary care, including effective use of physician extenders—mainly nurse practitioners and physician assistants. The unacceptable ratio of primary care to medical specialists (one-third to two-thirds) is not a minor factor best left to medical school deans, professors, and students; rather, it is threatening the financial viability of Medicare. Based on our analysis of factors driving healthcare costs, we estimate that the 1:2 ratio of primary care physicians to specialists is costing Medicare—and the country—several billion dollars per year.

Focus still more attention on the management of individuals with chronic disease, or people who are likely to become chronically ill. Some refer to this strategy as prevention, and in some respects it is. But for the millions who already suffer from diabetes, congestive heart failure, chronic obstructive pulmonary disease, or asthma, much more effort is needed to encourage patient adherence to clinical guidelines. The care coordination efforts at Catholic Medical Partners in Buffalo, N.Y., and at Geisinger in eastern Pennsylvania are examples of the type of joint health plan and physician group efforts needed for these types of patients. The pilot programs at Memorial Hermann, summarized earlier, also demonstrate what can be accomplished.

Pass tort reform. This strategy should not be seen as a panacea, but in the very least, putting a cap on noneconomic damages offers one relatively simple way to contain insurance premiums and reduce defensive medicine (part of the huge category of waste identified by Thomson Reuters and others). It also would take away some physicians' excuses for not making more serious efforts to reduce costs.

Discourage the use of physician-owned ASCs, imaging centers, and specialty hospitals. The ACA limits the

formation of new physician-owned specialty hospitals, but there is a lack of control over the expansion of ASCs and imaging centers. For those interested in bending or flattening the cost curve, continued expansion of many of these types of organizations is counter-productive. Health plans and employers should carefully evaluate the impact of these types of centers on healthcare costs in their communities before doing business with them. Our research and experience suggests that when purchasers analyze the total picture—including impacts on utilization rates and negative impacts on community not-for-profit hospitals and the communities they serve—they will see that these types of facilities often drive up overall healthcare costs.

Encourage the formation of multispecialty group practices and integrated systems. Concerns have been voiced about these kinds of groups becoming too powerful in their markets and violating antitrust laws, but such concerns should be balanced against many of these systems' strong track records in effectively coordinating care and controlling costs. The Marshfield Clinic in Wisconsin and Intermountain Healthcare in Utah and Idaho, as just a couple of examples, are national leaders in implementing clinical information systems and monitoring utilization of hospital and specialty services.

Reduce administrative complexity. Much has been written on this topic over the years, with cost estimates ranging from 25 to 30 percent. Although such estimates may be high, there is no doubt that the fragmented nature of the U.S. healthcare system adds billions of dollars a year to the cost of health care. As noted earlier, Thomson Reuters estimates these costs to be in the range of \$100 billion to \$150 billion per year.

HFMA and others continue to work toward invoices that patients can understand. Health plans and physician groups are seeking ways to avoid duplicative efforts to manage care for chronic patients. Healthcare attorneys and regulators are attempting to simplify approaches to antitrust and fraud and abuse under ACO-like organizations.

Stop accepting excuses that physicians and hospitals cannot cover their costs under Medicare and therefore need to shift costs to the private sector. We know that for many specialists (e.g., spine surgery, hip and knee replacement), profits from Medicare can be quite lucrative. Moreover, primary care, if practiced in a group setting and with the support of clinical IT, can cover its costs. New West Physicians in Denver and other organizations have proven that. Site visits performed for HFMA's Value Project disclosed that a number of hospitals and health systems are focusing on this issue. Shifting costs to the private sector based on poor payment from Medicare is counterproductive and must be reduced or eliminated if the nation is to bend the overall healthcare cost curve.

Expect more from the customer. Physicians and others argue repeatedly that patients need to play a role in reducing the high cost of U.S. health care. As one health policy analyst said at a recent conference, "All the work you are doing on health policy and bending the cost curve will be for naught if we don't make progress in the battle against obesity." Of course, efforts to address obesity and other health-related issues affecting Americans also will play a role in helping to prevent chronic disease, thereby contributing to progress in this area, as well.

And progress is being made, but with only a small part of the population. Geisinger's ProvenCare processes encourage patients to participate to receive the benefits of a discounted insurance benefit. As another example, Duke Medicine in Durham, N.C., is using its Integrative Medicine Programs to help strengthen patients' internal motivation by tying lifestyle-based health improvement to self-awareness and overall personal goals. And more broadly, many employers have added incentives for their employees to take specific actions.

Develop strategies that work for end of life. By many analyses, the United States' higher medical costs compared with those in other countries are almost all due to higher spending on care for seniors, and especially costs in the last year of

life. Some healthcare systems are bolstering their approaches to palliative care. The Institute of Medicine has slated a major analysis of end-of-life care for 2013.

The Realm of the Achievable

There is good reason to be optimistic that the healthcare cost curve can be bent. Moreover, the findings of our own and others' research suggest that the potential savings in health care are massive. The necessary changes won't happen overnight, but a focus on the 10 initiatives discussed here could exert significant downward pressure on the cost curve.

It is clear from our research that many organizations are successfully reducing costs. But will the necessary industrywide changes occur fast enough to ease the burden on the national economy and federal deficit? To achieve that kind of result, everyone—payers, physicians, health systems, policymakers, communities, employers, and patients—must play a role. ●

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