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Reducing the Total Cost of Care

A REPORT FROM HFMA'S 2018 ANNUAL CONFERENCE

SUMMER 2018

Bringing down costs in health care requires innovation and cooperation across stakeholder groups, starting with a willingness to have the right kinds of conversations.

In an era when patients bear an increasingly high portion of healthcare costs, the need to control and even reduce costs becomes ever more urgent.

A range of potential approaches can help providers tackle costs, with the experiences of successful organizations providing a roadmap. Those experiences and other insights were detailed as part of a cohort track, Reducing Total Cost of Care, at HFMA's 2018 Annual Conference in Las Vegas. The cohort was sponsored by 3M.

In six sessions over two days, attendees heard from a variety of industry experts on ways to tackle the cost problem in health care.

TOPICS ADDRESSED IN THIS REPORT INCLUDE:

- Creating a healthcare system that truly delivers value
- Building the business case to address social determinants of health
- Establishing finance-clinical partnerships to ease the transition to value
- Taking better care of patients who have the costliest and most complex conditions
- Establishing health plan-provider partnerships to improve value
- Bending the cost curve from an actuarial perspective

THE NEW CONVERSATION ON COST

Keys to improving access to care include transparency, appropriateness, and affordability, some leading healthcare policy advisers say.

An explosion of medical capability has occurred since the 1960s, "and our capacity to pay for that capability has never really even had a chance to keep up," said Neel Shah, MD, assistant professor of obstetrics, gynecology, and reproductive biology at Harvard Medical School.

HEALTHCARE COSTS AFFECT EVERYBODY

Source: Hamel, L., Norton, M., Pollitz, K., et al., "The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey," Kaiser Family Foundation, Jan. 5, 2016.

Presentation by Chris Moriates, Dell Medical School at University of Texas at Austin, and Neel Shah, Harvard Medical School.

Healthcare costs have traditionally been hidden—not just from patients but also from providers, Chris Moriates, MD, assistant dean for healthcare value at the Dell Medical School at the University of Texas at Austin, said during a presentation with Shah.

Key questions that providers need to answer include, "How much does it cost?" and "Is it even worth it in the first place?" said Shah, founder of Costs of Care, a global nongovernment organization that curates insights from clinicians to help delivery systems provide better care at a lower cost.

"Turns out about a third of the things that clinicians like us recommend are not worth it, but we don't have those conversations," Shah said.

In the case of treatments that are necessary but also expensive, a key question is, "How do I afford it?" he said.

Shah and Moriates co-wrote a *JAMA* paper called "First, Do No (Financial) Harm," which discussed medical bills as a cause of financial harm for patients.

"It's something that we have no control over," Moriates said, by way of describing a common outlook among clinicians. "I ordered the test. If you get a bill in the mail a month later that you can't pay for, sorry. Not my fault."

His organization created a high-value care committee, which was headed by Moriates and a financial administrator.

"Instead of the physicians talking about quality of care and the financial people talking about cost of care and how we could cut waste, we came together, and we found areas to work together," Moriates said.

Study Provides Insights on Value-Based Care

HFMA collaborated with Leavitt Partners and McManis Consulting, with support from The Commonwealth Fund, on a study that examines whether early experiments with value-based payment models reduced the total cost of care. The study explores the state of the volume-to-value transition and offers recommendations for accelerating progress. The report is available at hfma.org/tcoc.

The effort helped cut waste, including by reducing transfusions at the hospital, and saved more than a million dollars in real costs in the first year.

"It's now compounded to many millions of dollars over the last few years," Moriates said.

Moriates suggested that providers begin to look for savings through implementation of the Choosing Wisely campaign. However, he noted, cutting waste in hospitals is not going to trickle down to patients.

Instead he urged a focus on ways to "cut out the things we do for no reason and [to] help people get the care that they need. This is our challenge."

For patients at high financial risk, Shah said, providers could consider performing arbitration with the payer or activating new resources, like a health coach.

Among patients at moderate risk, Shah suggested more effectively coordinating existing resources, such as through social work or elder services.

"For those highest-need patients, maybe they truly do require the most resources—just like our highest-need cancer patients often have a tumor board—where we bring together all the different subspecialties—often case workers, social workers—to really help them navigate not only the clinical consequences of their care, but the financial consequences, too," Shah said.

MAKING 'CENTS' OF SOCIAL DETERMINANTS OF HEALTH

Healthcare leaders are struggling with how to tackle the social determinants of health in a way that's sustainable for society and the communities that they're trying to help and for their organizations and margins.

"In an ideal world, government—our governments, local governments, the federal government—would be addressing issues like hunger and homelessness and opioids and addiction, all of the social determinants of health," said Natalie Teear, director, Health Industries Advisory Practice, PwC. "We all know that's not the case."

The resulting costs are hitting the private sector. However, Teear noted it doesn't make sense for hospitals and other private entities to intervene on everything; resources are constrained.

In one case study, Teear urged healthcare executives to think about the money that they're already spending on things like procurement, workforce, investment, and facilities.

"Think about how to take that spend and … redirect it," Teear said. "Not spend more, but just spend better in a way that boosts health and well-being everywhere, but particularly in the communities that you serve."

In the example, she highlighted how one health system largely operates in suburban areas and spends a significant amount of money on parking garages and subsidizing those for its employees.

"How can this organization think about the money that it's spending to subsidize traditional gas-based commuting, and redirect it toward electric vehicles or public transportation?" Teear said.

The health system also made a big investment in affordable housing, from which it obtained a decent ROI.

Teear also worked with a large health system to use predictive analytics to quantify the current impacts and then model out potential future impacts of its community benefit strategy. That approach allowed the system to make the best choices with a limited budget and "get the most bang for their buck."

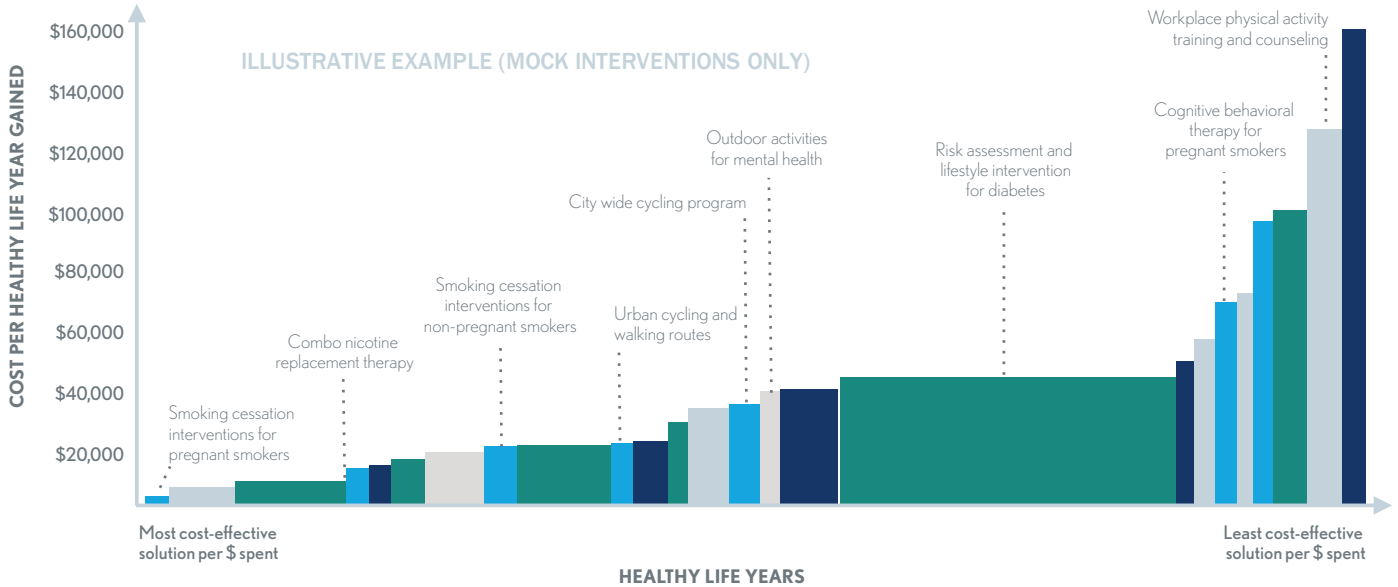
The health system examined a portfolio of 21 potential upstream interventions to determine how to allocate funds. Teear built a virtual population reflective of the city where the health system wanted to focus and incorporated variables related not only to income, ethnicity, and age, but also to behavioral and physiological characteristics.

The projected impact on healthy life years and well-being allowed the health system to prioritize the interventions, take a portfolio review, and look at the interventions on a cost curve. Once they were ranked, the health system found smoking cessation interventions for pregnant smokers led other options in the cost-benefit analysis (see the exhibit below).

In addition, risk assessment and lifestyle intervention for diabetes merited prioritization "because there were so many patients, so many people who were impacted by that type of an intervention," Teear said.

"These are the types of questions that you can keep in mind when you're thinking about the tradeoffs of how to best spend your money," Teear said. "If you have limited budgets, where are the right places to focus?"

Another emerging option in recent years is partnerships and alliances around social determinants of health.



OPTIMIZING A COMMUNITY HEALTH PORTFOLIO BASED ON LIKELY ROI

Source: Presentation by Ginger Pilgrim and Natalie Teear, PwC.

"You're seeing partnerships in ride-sharing," Teear said. "A few years ago, that was pretty innovative. Now, you see these partnerships with Uber and Lyft springing up all over the place. It's really fun breaking down the barriers to solve common problems."

She urged health systems to take an ROI-focused and portfolio-optimization approach to spending resources in a way that has a better impact on the social determinants of health.

In a table exercise with attendees at the cohort session, Ginger Pilgrim, principal, Health Industries Advisory Practice, PwC, found the interventions that ranked highest were assisting with access to healthy foods followed by assisted housing.

"We hope that you leave here with a thought process around maximizing the impact of the spend that we're all spending across the country in all of our institutions," Pilgrim said. "How can we think through that in a way that can have the most impact?"

SMOOTHING THE PATH TO FEE-FOR-VALUE WITH PARTNERSHIPS

One key to smoothing the transition to value-based care is a wider integration of multiple care team members, said executives with a health system that has found success in such models.

At Yale New Haven Health, team members such as social workers "needed to become even more involved," said Keith Churchwell, MD, senior vice president and executive director of cardiovascular services, transplantation. "We needed to have an opportunity to integrate their work into the clinicians' work in a much more granular way that allowed us to follow these patients much more effectively and actually have a major impact."

Yale New Haven's implementation of value-based payment focused on getting care coordinators to work together with cardiologists and primary care physicians to improve results, said Stephen Allegretto, CPA, system vice president for value innovation and shared value partnerships.

In examining high-cost cases, the organization found that adverse events generated more revenue but also costs that outweighed the additional revenue.

"In other words, the more we do, the less we make; we never understood that longitudinally," Allegretto said.

"For those highest-need patients, maybe they truly do require the most resources—just like our highest-need cancer patients often have a tumor board—where we bring together all the different subspecialties to really help them navigate not only the clinical consequences of their care, but the financial consequences, too."

—Neel Shah, MD, Harvard Medical School

The data led health system leaders to focus on reducing overall variation, Churchwell said, which would decrease the chance for a complication to occur.

From the perspective of a finance leader such as Allegretto, the data underscored the need to establish a collaborative relationship with physicians who take care of the high-cost patients.

"Physicians, we tend to not trust administration right off the bat," said Alon Ronen, MD, cardiologist, NEMG-PriMed, Yale New Haven Health. "Trust is something that we build on, it's not something that's actually given immediately."

A factor that helped establish credibility was senior leadership's efforts to meet with the clinicians on a regular basis and be engaged in the program.

"There was no history of a shared-value program in cardiology, but the team constituency actually brought some credibility" to the conversations, Ronen said.

Additionally, once the clinicians achieved the target metrics, "We were actually compensated the way we were supposed to be; there was no going back for budgeting," Ronen said.

Another key, Churchwell said, was "building appropriate checks and balances for programs that clinical, financial, operations folks would agree on."

The effort produced a "signature service line approach," which aimed to reduce cardiovascular care variation.

The strategy invested in physician-led care teams that consisted of care coordinators, primary care physicians, and specialists. The approach allowed administrators to address clinician pushback on the accuracy of outcome metrics and variation indicators.

"But there is a specific population within the data that tells us that we have an opportunity in regard to changing what we can do, changing it for the better," Churchwell said.

The initiative focused on the improvement opportunity shown in the data on adverse events.

"We made a pact with the physicians that the key was actually getting the problem list right and the medication list right," Churchwell said.

The initiative invested in physicians to "go back and use your expertise to ensure that the data is correct as we look at this patient population," Churchwell said.

Another key was linking a cost-accounting system with readmissions and quality variation indicators as a way of measuring the financial impact of outcomes, Allegretto said.

"I think we can actually change health care one physician at a time by partnering with them in a different way," Allegretto said.

TAKING BETTER CARE OF HIGH-NEED, HIGH-COST PATIENTS

As providers increase their focus on cost, they face unprecedented complexity, especially on the payment side with increasing amounts of risk, one industry observer says.

David Blumenthal, MD, president of The Commonwealth Fund, said such challenges will continue given that U.S. Department of Health and Human Services Secretary Alex Azar II has committed to continuing to implement value-based payment (VBP).

Blumenthal noted that VBP still is not fully defined, but it involves greater accountability for cost, greater risk, and greater complexity.

"The question is, in the face of this, how do you manage your way through the thicket of risk accountability and cost that you face in your organizations every day?" Blumenthal said.

He argued that navigating such risk requires better management of high-need, high-cost patients.

That conclusion stems from consistent findings that about 5 percent of the population accounts for 50 percent of healthcare spending, and the elderly make up a disproportionate number of such patients.

"If you are, or when you are, taking risk for the total cost of care for a population, I think that you will need—if you haven't already—to focus like a laser on high-need, high-cost patients," Blumenthal said.

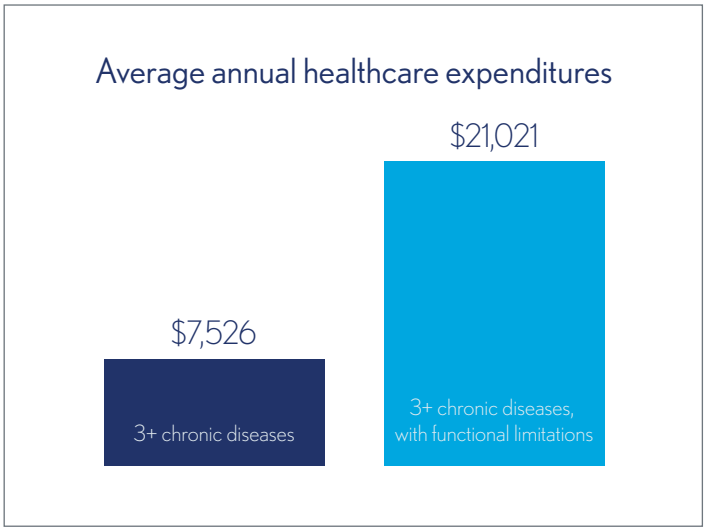
The solution to better caring for them begins with understanding who they are. They tend to have multiple chronic conditions, be poorer, and have non-healthcare needs like nutrition, housing, and transportation. Other predictors of their healthcare resource use are frailty and functional limitation (see the exhibit at right).

Another important predictor of high-cost patients is behavioral health.

"Take any illness, any chronic illness—COPD, CHF, CAD, diabetes, hypertension—and add a behavioral health problem, and you double or triple the average annual cost of caring for that individual," Blumenthal said.

However, such patients also are a heterogeneous population.

Although large-scale innovation has been difficult to achieve in health care, Blumenthal thinks the prospect of risk-based payment has the potential to clear away or reduce some of the obstacles to translating microsystem innovations to the wider healthcare macrosystem. Such innovations will boost the care of high-need, high-cost patients.



FUNCTIONAL LIMITATIONS ARE A KEY PREDICTOR OF HIGH COSTS

Data: 2009–2011 Medicare Expenditure Panel Survey. Noninstitutionalized civilian population age 18 and older.

Source: Hayes, S.L., Salzberg, C.A., McCarthy, D., et al., "High-Need, High-Cost Patients: Who Are They and How Do They Use Health Care?" The Commonwealth Fund, August 2016.

Presentation by David Blumenthal, The Commonwealth Fund.

"I think we can actually change health care one physician at a time by partnering with them in a different way."

—Stephen Allegretto, CPA, Yale New Haven Health

Among the findings from The Commonwealth Fund's analyses of microsystem reforms that have worked is the importance of stratifying patients according to clinical need.

A second vital step is investment in care coordination. An example is the CareMore program, which was founded about 25 years ago in California and now exists in six states. It uses a new kind of health professional called an "extensivist," who specializes in the care of this population as part of a multidisciplinary team.

Preliminary results indicate the program reduces hospital admissions and may lower costs.

The Commonwealth Fund also has created an online resource (bettercareplaybook.org) for healthcare organizations seeking guidance on caring for high-need, high-cost patients. The playbook includes a beta test of an ROI calculator for investments in managing the social determinants of health.

Blumenthal cautioned that software does not yet exist for stratifying patients by clinical segment to determine what action is needed and what care would be best for them. Researchers examining that need through claims data have found that high-cost patients one year may not be high-cost the next.

Another note of caution: Financial incentives for organizations to invest deeply in care coordination don't exist in a fee-for-service payment system.

"Once you have risk, the equation changes," Blumenthal said.

HEALTH PLAN AND PROVIDER COLLABORATION TO IMPROVE OUTCOMES, REDUCE TOTAL COST OF CARE

Some healthcare organizations have identified payer-provider partnerships as a key to mutual success in value-based payment programs.

Blue Cross and Blue Shield of Louisiana and the Baton Rouge Clinic, an independent, physician-owned multispecialty clinic, participate in the Quality Blue Value Partnerships, the insurer's shared-savings program. The program for the commercial population at Blue Cross and Blue Shield of Louisiana contracts with 25 accountable care organizations (ACOs) across the state.

The Baton Rouge Clinic was one of five original provider partners in the total-cost-of-care program, which centers on primary care physicians.

A methodology is used to attribute patients to the participating provider organizations and then evaluate providers based on how well they manage the cost trend for those patients.

Among three keys to the success of the program, one was competency, with the insurer striving to manage providers' questions and create a high degree of credibility so participants felt comfortable with the data that were presented.

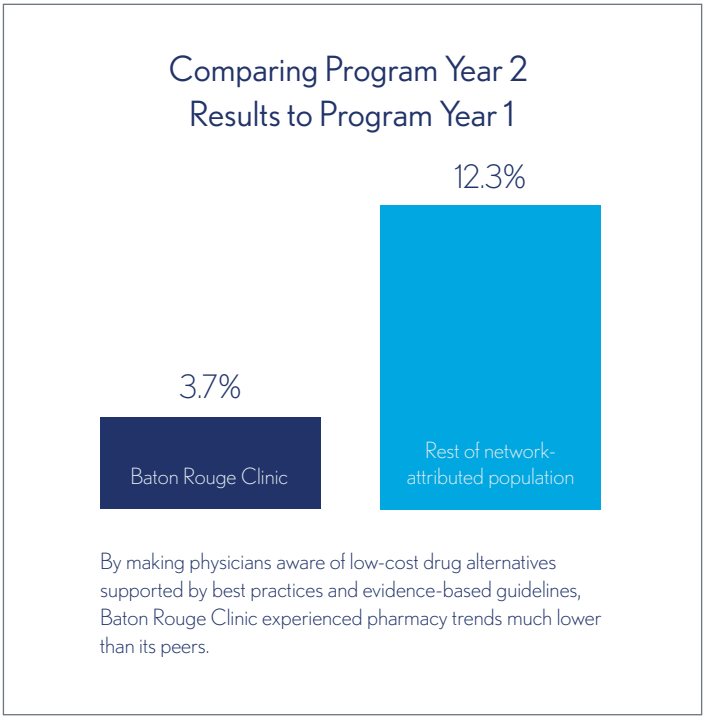
The next key was flexibility, which entailed working in a consulting role with the providers instead of dictating to them.

A third key was the availability of leaders on both sides to consult with one another as needed.

"There were a million reasons why I didn't believe what Blue Cross had to say about my practice," said Shunn Phillips, CPA, the CFO of Baton Rouge Clinic. "We had to work through that; that took my time, it took my staff's time."

The insurer's data on drug costs proved particularly helpful, Phillips said. "Not only did they give us a list of their high-cost medications, they gave us the ones that we were prescribing," she said. Baton Rouge Clinic then took that data and used it to create a best-practice advisory in the electronic health record (see the exhibit at right for the effect on pharmaceutical costs).

The insurer provided data not only on what was happening inside of the practice but on what its patients were doing outside, such as how often they were accessing care from other organizations.



RESULTS OF THE QUALITY BLUE COLLABORATION: RISK-ADJUSTED PHARMACY TREND ANALYSIS

Source: Presentation by Natalie McCall, Blue Cross and Blue Shield of Louisiana, and Shunn Phillips, Baton Rouge Clinic

The insurer built a team of analysts to work with the providers in a consulting capacity, analyzing data, presenting results, answering questions, and then monitoring progress over time.

On the provider side, physicians who delivered patient care met directly with the insurer and its analysts. That helped clinicians make decisions at the point of care, having been a part of the leadership and strategy conversations with the insurer.

"Take any chronic illness and add a behavioral health problem, and you double or triple the average annual cost of caring for that individual."

—David Blumenthal, MD, president, The Commonwealth Fund

"It also helped us gain buy-in from physicians that weren't necessarily in the room because we didn't have only administrative physicians talking about how to deliver care," Phillips said.

Blue Cross and Blue Shield of Louisiana aggregated the data in a trend-based way to help provide insights about the practice patterns of specific physicians.

The clinic took the insurer's data and used it to predict future patient needs, such as knowing what time of day people were typically going to the emergency department, what day they were going, and where they were coming from.

"The details were extremely important to us when we started the process because we could not get here if we did not trust the data that they were bringing to us," Phillips said.

The collaboration's ongoing updates come through a joint operating committee that can identify trends such as an increase in ED use. The organizations can then do a deep dive into the data and identify the types of visits, where enrollees are going, and who their primary care physicians are.

"Then, of course, at the end, we'll collaborate on what interventions might need to take place to curb those trends," said Natalie McCall, ACO program director at Blue Cross and Blue Shield of Louisiana.

ASK AN ACTUARY: HOW TO BEND THE COST CURVE

Providers increasingly are looking at ways to fundamentally change the way that high-cost patients interact with the healthcare system and examining what sorts of approaches can bend the cost trend.

The challenge is complicated by the common experience of providers that have found positive results from focusing on the high-cost patient population in one location but then have been unable to migrate the program to another location, said Rebecca Owen, consulting actuary, HCA Solutions, and a fellow of the Society of Actuaries.

The common finding that 5 percent of claimants drive 50 percent of healthcare spending is compounded by the fact that three-thousandths of a percent of patients have claims in excess of $1 million—and that share is growing.

"We have some good reasons that we understand," Owen said. "They tend to use new drugs, advanced therapies, and they reflect the aging and more complicated demographics of the United States."

To manage the high-cost patient trend, providers need to address chronic disease, which includes managing the number of events, the cost of each event, or some mix of the two.

Unfortunately, efforts to address high-cost patients through changes in insurance benefit design—by requiring more skin in the game—can actually worsen costly conditions by raising financial barriers to chronic illness treatment.

High-cost claimants can be identified in claims or in enrollment files, with most being older and female. The data are mineable and can be used to create prospective diagnostic risk adjustment models.

However, the resulting scores have produced many false positives, Owen said.

The "Reducing Total Cost of Care" Cohort

The New Conversation on Cost

Chris Moriates, MD, assistant dean for health care value and assistant professor, Department of Medicine, Dell Medical School at University of Texas

Neel Shah, MD, assistant professor of obstetrics, gynecology and reproductive biology, Harvard Medical School

Making 'Cents' of Social Determinants of Health

Ginger Pilgrim, principal, Health Industries Advisory Practice, PricewaterhouseCoopers (PwC)

Natalie Teear, director, Health Industries Advisory Practice, PricewaterhouseCoopers (PwC)

Smoothing the Path to Fee-for-Value with Partnerships and Relationship Management

Stephen Allegretto, CPA, system vice president, value innovation and shared value partnerships, Yale New Haven Health

Keith Churchwell, MD, senior vice president/executive director, Cardiovascular Services, Transplantation; and clinical services coordinator, medicine, Yale New Haven Health

Alon Ronen, MD, cardiologist, NEMG-PriMed, Yale New Haven Health

Dan Michelson, CEO, Strata Decision Technology

Cracking the Cost Code: Taking Better Care of High-Need, High-Cost Patients

David Blumenthal, president, The Commonwealth Fund

On the Same Side of the Table: Health Plan and Provider Collaboration to Improve Outcomes, Reduce Total Cost of Care

Natalie McCall, accountable care organization program director, Blue Cross and Blue Shield of Louisiana

Shunn Phillips, CPA, CFO, Baton Rouge Clinic

Ask an Actuary: How to Bend the Cost Curve

Rebecca Owen, consulting actuary, HCA Solutions, Fellow of the Society of Actuaries

"While these are very good and improving constantly on a population level, for each individual—and particularly for each costly individual—they're not that good," Owen said. "They don't tell you a lot about the person; you either miss people or you over-identify people."

Additional insight can be gained from talking to these patients, specifically from open-ended questions such as, "How have you felt this week?" The response to such questions can elicit more important feedback than complex standardized questionnaires, Owen said.

Instead of asking about income, for example, providers can ask patients whether they ever have trouble affording their prescriptions "as a way of finding out if this is a person who has some of these socioeconomic indicators that might indicate, along with their predictive score and their pattern of use of the system, that they're really a complex high-need patient," Owen said.

Once those patients are identified, corresponding interventions may be complex. There may be a need to find not just a translation service, for example, but someone from a certain ethnic community who could speak directly to the patient from a position of trust and who understands the patient.

Among such patients, it also may not be possible to prevent a hospitalization.

"With these top percent, you maybe want to manage the transition into the hospitalization that's come up," Owens said. "It's almost humbling."

Remaining questions in efforts to implement innovative tailored approaches include figuring out how to fund them.

"The question of, 'If you want to bend the cost curve, are you going to be able to avoid doing tailored approaches, particularly for the exceptionally high-cost patient?' I don't think that's the question," Owen said. "I think the question is: Who pays for it?" +

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HFMA would like to thank 3M for supporting the Reducing Total Cost of Care cohort track at the 2018 Annual Conference. The cohort included six sessions, each featuring discussions among audience members and Q&As with presenters.

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COMING UP

HFMA's 2018 Revenue Cycle Conference takes place Oct. 21-23 in Denver and examines the impact of consumerism and innovation on the ability to provide a seamless patient financial care experience. Visit **hfma.org/rcc** for details.

And don't forget about HFMA's 2019 Annual Conference, June 23-26 in Orlando.

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ABOUT HFMA

With 38,000 members, the Healthcare Financial Management Association (HFMA) is the nation's premier membership organization for healthcare finance leaders. HFMA builds and supports coalitions with other healthcare associations and industry groups to achieve consensus on solutions for the challenges the U.S. healthcare system faces today. Working with a broad cross-section of stakeholders, HFMA identifies gaps throughout the healthcare delivery system and bridges them through the establishment and sharing of knowledge and best practices. It helps healthcare stakeholders achieve optimal results by creating and providing education, analysis, and practical tools and solutions. HFMA's mission is to lead the financial management of health care .

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