Making Cost Containment Stick in the New Healthcare Economy

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As senior vice president of strategy, business development, and technology at Truman Medical Centers (TMC) in Kansas City, Missouri, Mitzi Cardenas is used to doing a lot with very little. In fact, this experience serves her and her colleagues well as they pursue strategic cost-containment initiatives. “It’s challenging, but in some ways it is advantageous,” she says.

Because TMC is a safety net, its leaders have been forced to develop a sophisticated vision around cost reduction, using population health management and targeted metrics as the foundation for growth and change. One of the health system’s key strategies is including cost-containment measures in the annual budgeting process.

“I’ve been in healthcare for a long time, and measures can work really well for a short period of time, but getting them to stick on an ongoing basis is challenging,” Cardenas says. To that end, a powerful group of TMC leaders meet monthly to set and hardwire cost-containment initiatives.

Cardenas says TMC, which includes two acute care academic hospitals, a behavioral health program, a long-term care facility, and multiple primary care practices, has taken major steps over the last few years to slash costs, including overhauling its coding operations (as ICD-10 went live) by providing outsourced coders and computer-assisted coding. TMC also implemented a voluntary separation program for staff, established a clinical documentation improvement (CDI) program, and made critical revenue cycle enhancements. The labor adjustments alone resulted in $6.5 million in savings last year, Cardenas notes. The organization also has made strides to ensure that eligible patients are enrolled in the Health Insurance Marketplace or Medicaid, thus reducing uncompensated care last year for the 21,000 uninsured/underinsured patients for whom TMC manages risk, which was $120 million at cost last year. This included creating a new program to drive greater enrollment in the Health Insurance Marketplace. Overall, thanks to leadership’s strategic cost-containment initiatives, TMC is on target to save $9.8 million this fiscal year.

The reality of cost containment in 2016

This year, Cardenas and other finance leaders say they are focused more than ever on driving down costs in order to match reimbursement losses. They are also looking to grow their margins to make important investments in technology and infrastructure, among other areas. “We are looking at how our reimbursement might change over the coming years and how we can keep people healthier while not overutilizing services,” says Cardenas.

At MemorialCare Health System in Fountain Valley, California, CFO Karen Testman, RN, says she is most concerned about cost-reduction efforts keeping pace with reimbursement reduction, particularly given the tight nursing labor market. “Revenue reductions are coming so fast that it’s a challenge to keep pace with that in terms of cost reductions,” says Testman.

Other challenges include reducing costs to generate the margin required to invest in needed capital projects, IT and other physical and digital infrastructure, and diagnostic and treatment technologies. “IT and infrastructure investments required to stay competitive and succeed in a population health and wellness-focused environment have become very expensive,” Testman says. “We need to make sure that we’re well positioned for overall transformation in healthcare delivery.”

A June 2015 HealthLeaders Media survey on strategic cost control also sheds insight on the top financial priorities for healthcare leaders. The survey, which polled 324 healthcare leaders, found that the top three challenges in

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creating sustainable cost reductions are having actionable data on the true cost of care, insufficient integration with care partners, and lack of technology in place to achieve goals. Additionally, the majority of respondents maintained that revenue cycle improvement efforts and cost-containment efforts are nearly equal when it comes to maintaining or improving margins. Participants also said that among operations or administrative activities, those that provided the highest dollar value in cost-containment contributions for the fiscal year were, in order, purchasing and supply chain efficiencies, process redesign, and consolidating/centralizing business functions. In addition, among clinical activities, the top three were efficient use of clinical labor, care standardization, and improved utilization of clinical resources.

Here, industry leaders discuss five important strategies that are driving successful cost-containment efforts in 2016.

1. Mastering centralization and standardization

Faced with declining reimbursements in 2007, MemorialCare created a bold goal of generating a margin on its Medicare business, says Testman, noting that like most healthcare organizations, Medicare covers only 80% of MemorialCare’s costs. “Low government payments always outsize normal cost increases, so the challenge is continually how to reduce our costs in this environment,” she says. MemorialCare implemented a broad strategy that involved focusing on productivity, lean management, utilization management, and care model redesign. One important step included centralizing most business functions, including revenue cycle, legal, accounts payable, and payroll, across the health system’s five hospitals. “We achieved significant cost savings and efficiency as a result of these efforts,” says Testman.

MemorialCare also has worked to standardize care through its centers of excellence in joint replacement, cardiac surgery, and breast health, as well as through its population health initiative that focuses on better care coordination for patients with diabetes, hypertension, asthma, and other conditions. “We’re also moving forward now to redesign workflow in our clinic locations,” says Testman. These efforts have resulted in $146 million in savings systemwide since 2010, she adds.

2. Data analytics: Charting a new course for the future

Savvy leaders understand that the path to population health management and lasting cost containment involves having the right cost data, including a deep understanding of the true cost of care. Testman agrees that data has been crucial for reducing costs. “We have very good data on the cost of care for the care that we’re providing at our facilities, clinics, and for the claims that we’re paying for our at-risk members,” she says, noting that MemorialCare takes on risk for 250,000 individuals in managed care and ACO arrangements. But as the organization continues to grow its at-risk membership, it is working with health plans to get more data. “Health plans typically have the largest amount of data, and we are always striving to increase our data capabilities,” says Testman.

Physicians play an important role in harnessing the power of data analytics, Testman notes. “Our priority is getting data in the hands of our physicians, and we have done that by putting in place a data portal for physicians that contains comparative information on quality and cost by physician to help them identify opportunities to reduce variability.” The 2,000-member MemorialCare Physician Society oversees best practices, while physicians, nurses, and other clinicians help develop standard care maps to improve utilization and quality. “Most recently, these teams are focusing on overdiagnosis and reducing unnecessary tests, which then reduces costs and improves care and the experience for the patient.”

Testman adds that MemorialCare is in the process of continuing to expand its population health and data analytics platform. “It helps us better understand the total cost of care, identify high-risk patients who we need to intervene with on a regular basis, and it will ultimately enable us to do better predictive modeling.”

3. Revenue cycle: The details become the story

MemorialCare has also made strategic revenue cycle changes in the last few years, including small tweaks as well as brand-new services. “It has resulted in some fairly significant cost savings and improved patient satisfaction,” says Testman. For example, MemorialCare recently redesigned its patient statement, making it much easier to read. “The outcome has been fewer patient questions, much happier customers and patients, and a reduction in costs,” says Testman.

Also, she notes, MemorialCare unveiled a concierge service in January 2015 for specific elective cases. These patients are assigned a single customer service concierge who works with them through the entire care and billing process. “Our goal is to collect the patient’s share of the cost up front, which obviously reduces costs on the back end,” says Testman. “The result so far has been outstanding. We’ve surveyed our patients and they are very happy with the process, and at the same time we’re collecting more funds up front and reducing our costs on the back end.” MemorialCare plans to expand the program to handle all elective cases under this concierge model, she says.

TMC is also making significant revenue cycle changes, including moving to a single IT vendor for clinical and financial systems, and providing opportunities that help move more uninsured patients into insurance plans. In addition, it is looking at different tools to improve third-party eligibility processes, and it has implemented a program that automates address verification. “Automating address verification has been a pressing issue for us,” says Cardenas. “We had a lot of incorrect addresses in the system, making it impossible to bill correctly.”

TMC’s CDR program also resulted in $1.2 million in savings over a five-month period. The program ensures documentation accurately reflects the care that is provided by reviewing diagnoses and making sure codes are assigned at the highest appropriate degree of specificity. This has resulted in more accurate patient acuity, which has impacted
reimbursement, says Cardenas, noting that TMC’s case-mix index has gone up significantly since the start of the program.

4. Thinking differently about patient care innovations

Grand Rapids, Michigan–based Spectrum Health, a not-for-profit integrated delivery network that includes 12 hospitals, a 721,000-member health plan, and 178 ambulatory and service sites, has been proactive in developing programs that drive patient care and patient experience innovations while bending the cost curve and tying into efforts related to value-based care. Kenneth Fawcett Jr., MD, vice president of Spectrum Health Healthier Communities, says the organization’s Core Health program aims to address the full needs of underprivileged and economically disadvantaged populations who are higher utilizers of acute care services, have a chronic disease, or live in impoverished conditions.

“We know that among vulnerable populations, these individuals have a greater burden of chronic disease, their life expectancy is reduced, and the economic cost to the community is very high,” says Fawcett. “Being much more forward thinking about how we engage with these populations will greatly reduce medical expense to the community as a whole.”

The 12-month program offers medical and other services to participants in their homes. Care teams are organized by a registered nurse or a medical social worker who functions as a care manager. “The secret sauce of this program is we pair them up with community health workers, many of whom are former recipients of our program,” says Fawcett. The program teaches a curriculum on how to manage diabetes, congestive heart failure, and respiratory illness. At the same time, it helps individuals navigate other life barriers that impair their ability to engage with their health, such as finding reliable transportation and secure housing, as well as addressing food insecurity and health literacy.

“Typically, healthcare organizations may utilize the social determinants as a tool or as a guide in terms of how to apply more healthcare, but we’re actually looking at the social determinants as individual things that we should be targeting,” says Fawcett. By structuring the program this way, he notes, “we can achieve better health outcomes, and we actually find that we have a positive return on investment through cost avoidance, notably diminished ER and inpatient utilization for these conditions.”

For example, during 2015, inpatient length of stays for heart failure patients in the program dropped by more than 60%, going from 3.8 to 1.5 days and saving the organization nearly $4,000 per patient per inpatient stay at a Spectrum hospital in Grand Rapids.

Fawcett says he is looking at how to bring the program to other populations. “This particular model has applicability far beyond just vulnerable populations. We know particularly when we transition over to a value-based model of reimbursement that the importance of these services is going to be intensified.”

Spectrum Health is also looking to drive care and cost efficiencies through advanced telehealth offerings, says Joseph Brennan, senior director of MedNow, which was launched in 2014. “MedNow was started because everyone agrees that we need to move from volume to value,” says Brennan.

Under MedNow, Spectrum Health has centralized and standardized its telehealth initiatives into three main areas, including video visits with a specialist; remote monitoring services for patients with chronic conditions such as COPD, CHF, and diabetes; and direct-to-consumer visits that provide low-acuity and primary care services via a digital device. Brennan says the latter program, which serves 25 patients a day, is paving the way to reduce the cost of emergency and primary care. For example, he says, treating a cough, cold, or flu in the ER or urgent care setting costs about $370 compared to $45 for a visit via any type of device, including a cell phone, desktop computer, laptop, or tablet.

“When you think of the expense of going to the ED in general, and you replace that with a $45 visit that allows you to connect to a Spectrum Health medical group provider and you don’t have to leave your home or leave work, it’s not only beneficial for the patient, but there is also a real opportunity to reduce the costs of care,” says Brennan. In addition, patients are given a medical record that is shared with their physician regardless of affiliation, ensuring they are properly transitioned along the care continuum. “It’s a big differentiator for Spectrum Health,” says Brennan. In fact, he adds, new patients are coming to Spectrum Health “purely because of the cost and convenience of MedNow.”

5. Maximizing organizational strengths

The path to successful cost containment also involves recognizing and cultivating organizational strengths. “Cost containment has been embedded in our culture for decades,” says Testman. Additionally, a major advantage for MemorialCare is its extensive ambulatory network, she adds. “Being able to push more into the ambulatory environment is a big strength. Our investment in surgery and imaging centers, our clinic locations, and our medical group and IPA relationships have positioned us well and encouraged care to be provided in the most appropriate, convenient, and lowest-cost setting possible.” She notes that MemorialCare also benefits from a disciplined financial planning process. “Our sophisticated cost accounting system allows us to very consistently analyze our services and product lines’ financial performance, so we’re constantly able to drill down and look at what it costs us to provide care.”

TMC’s Cardenas points to a strong mission, targeted financial and clinical data, and a rigorous budgetary process. “Our primary strength is that we have always worked very closely because of our payer mix, our safety net status, and our mission,” she says. “Also, we now have better data and can more readily see if we’re improving or not and what we need to do to course correct.”
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1. What are the biggest challenges in understanding the true cost of care?
As the industry shifts toward population health initiatives and new value-based reimbursement models with the twin goals of reducing total cost of care and improving quality of care, it requires infrastructure investment and development. This introduces new, and often unanticipated, costs into the system that may not be readily visible to many people.

Such costs present challenges for healthcare organizations and contribute to an overall lack of cost transparency in healthcare. Two significant cost drivers include regulatory mandates and the complexity of the claims environment in recovering payments.

2. Can you give an example of a regulatory mandate and explain how it affects the cost of care?
This refers to a statute or regulation that requires healthcare organizations to perform certain actions or fulfill specific requirements. Often these mandates are designed to facilitate important, large-scale goals such as achieving long-term cost savings or improved quality for the healthcare system. Implementation typically requires a considerable up-front investment by healthcare organizations, which can lead to financial and productivity strains.

A good example was the requirement that all healthcare providers and health systems implement the ICD-10 coding system last year. ICD-10 was the first change to the U.S. medical billing and disease-tracking coding system in 30 years.

The goal of ICD-10 was to improve administrative efficiency and achieve better health outcomes and systemwide cost savings. To reap these benefits, preparing and transitioning to the ICD-10 platform required significant system changes and investments in time and resources.

Industry partners such as Optum360 provide technology solutions and services that can streamline processes and enable a smooth transition, while allowing the organization to focus on other priorities. For example, our clinical documentation improvement module automatically indexes all inpatient records to precisely identify and resolve missing or inconsistent clinical information concurrent to patient stay. This helps minimize the time and resources spent manually verifying documentation and delivers more comprehensive, precise results.

3. You also mentioned the claims environment. Can you explain how this is affecting the cost of care?
This refers to the time and money that providers and insurers put into collecting appropriate reimbursement. The back-and-forth between hospitals seeking to recover underpayments from payers and payers seeking to recover overpayments from providers is a friction point in the industry that increases the cost of care to the purchaser, without deriving any benefit. Data collected on this back-and-forth between payers and providers shows little net gain for anyone, making this another hidden cost that does not add material value for the consumer.

4. How can providers help reduce these hidden costs of care?
As healthcare organizations attempt to reduce costs and keep communities healthier under new reimbursement models, they must be prepared to support the administrative requirements of those reimbursement models. Over time, these new models should reduce the cost of care, but in the meantime there is an increased cost associated with the tools and administrative practices of putting them in place.

Technologies and solutions are available to help providers with these administrative needs, as well as identify opportunity areas to drive out costs and reduce friction between providers and payers. This is the mission of Optum360: helping make health systems work better for everyone by modernizing provider revenue and services management.

We work to strengthen relationships between payers and providers, build clear connections between cost and care, help providers put patients in control of their financial health, and ensure ongoing regulatory changes are implemented as efficiently as possible. For example, our computer-assisted coding technology helps improve the accuracy of claims and increase staff productivity. Through constant innovation, we’re working toward the goal of better alignment between payers, providers, and physicians, and solutions for the future.
FINANCIAL SUCCESS IS ACHIEVED WHEN THE BUSINESS OF HEALTH CARE IS SIMPLIFIED

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**Claims Management**
Achieve quick and accurate reimbursement

**Revenue Cycle Tools**
Streamline operations with real-time consistent data flow
Analyzing Reimbursement Trends That Impact Your Bottom Line

The Affordable Care Act has dramatically shifted the focus from volume-based to value-based care, and the discovery of revenue cycle issues is more important than ever.

“Quality of care is replacing fee-for-service and completely changing the revenue cycle,” said Will Israel, product manager for SSI, an industry leader in claims management technology. “Getting reimbursed for every dollar spent is paramount, especially as reimbursements continue to decrease. It becomes necessary for organizations to uncover trends and possible issues before entering payer-contract negotiations.” However, large volumes of unstructured data, a lack of interoperability and inadequate business intelligence tools prevent many providers from addressing their most significant revenue gaps.

Given growing volumes of patient data and increasing complex care scenarios, a cohesive software solution is necessary to tackle these issues. “Everyone needs an integrated system for business intelligence, analytics and data mining,” said Israel. “You need a system that triggers actions and sends notifications, and currently, there is a plethora of data from disparate systems that are unable to communicate with one another.” Providers might be able to determine the losses from a subset of denials, for instance, but ranking and organizing denials in order to prioritize those to correct first becomes a moving target. “You have to think about the entire revenue cycle, and you need a tool to highlight where you are out of balance,” he said.

Combined solutions, such as SSI Analytics, Contract Management and Denial Management, help providers bridge the gaps between claims data and targeted interventions. “We put a laser focus on denials of interest,” said Israel. “Analytics shows you what you need to fix, and Denial Management allocates the work to the right people.” While many legacy systems require administrators to read spreadsheets line-by-line and address each denial, solutions such as SSI’s can automatically prioritize high-dollar denials and allocate their management to the most qualified personnel.

Still, technology adoption alone cannot provide for sustainable process improvement. “The hard part is changing behaviors within an organization,” said Israel. “Given current slim margins, revenue team can’t afford to let data sit idle for weeks.” In some cases, the most beneficial behavioral change is as simple as improving the processes to ensure patients’ insurance eligibility is checked. In many instances, however, disparate data sets prevent revenue teams from finding the highest cost denials on which they should focus. “No matter the tool, bad data is just going to lead you to make bad decisions faster, and there’s no regulation that says one company’s system must talk to all the others,” he said. To create more complete data sets, SSI guides providers through the manual process of standardizing the language of the various record-keeping and data mining systems they use.

“Join this discussion, and you’ll see how critical modern analytics is in increasing revenue cycle and improving your bottom line.”

- Will Israel | Product Manager | SSI

Ultimately, new analytics tools will only become more critical in managing denials in the future. “As your patient population changes, you may see your organization’s area of focus shifting,” said Israel. “Revenue centers can always become cost centers, and it’s important to have a flexible, intelligent system to show what’s driving your revenue now and in the future.”

The SSI Group, Inc.
800.881.2739 | www.theSSigroup.com

Will Israel, MPH, CSBI