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The Tyranny of Average Costing:

Profit and COST in Value-Based Delivery

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By David Johnson, CEO

Michael Porter, the eminent Harvard Business School professor, defines "value" in healthcare as "achieving the best outcomes at the lowest cost."

Through evidenced-based protocols, health companies have invested substantial resources to deliver and document improved care outcomes, the first component of Porter's equation.

By contrast, health companies exhibit marginal understanding of their costs, the second element of Porter's equation. Porter characterizes the current state of healthcare cost management harshly,

"For a field in which high cost is an overarching problem, the absence of accurate cost information in health care is nothing short of astounding."

Outcomes and costs should go together like love and marriage. Given their "distant" relationship within most health companies, making outcomes and costs compatible will require serious intervention.

The Tyranny of Average Costing

Most hospitals use either Ratio of Costs to Charges (RCC) or Relative-Value Units (RVUs) methodology for allocating costs.

These methodologies blend direct and indirect costs into average cost units (e.g. one cost for knee implants). Finance applies these cost units to treatment codes for billing third-party payors.

RCC and RVUs are pure allocation methodologies that rely on broad assumptions and are easy to implement. Neither RCC nor RVUs incorporate rigorous activity or resource-use analysis. Instead, they generate high-level cost data to support revenue collection ("Job 1 at most hospitals) and produce departmental-level income statements.

Here's where "the tyranny of average costing" raises its ugly head. The system oppresses performance improvement in two important ways:

- The gross cost allocations mask the actual profitability and loss performance of individual procedures, clinicians and units. Overall profitability is accurate at the departmental level. Component profitability within departments homogenizes and is often wrong. Significant resource allocation mistakes happen.
- RCC and RVU cost allocations support billing, not clinical improvement. Clinicians have little understanding of cost allocations and their relationships to outcomes. They cannot combine their clinical knowledge with meaningful cost data to exploit opportunities for better outcomes at lower costs. Productivity improvement sputters.

Wrong-Headed Cost-Cutting

It gets worse. RCC and RVUs blind health companies to informed process improvement that reduces costs while maintaining or improving quality. Under financial pressure, companies adjust P&L expense categories (e.g. payroll) without understanding how line-item cuts will affect care productivity and outcomes. Too often, this approach to expense reduction leads to lower productivity and higher costs.

An insightful article in Harvard Business Review by Robert Kaplan and Derek Haas illustrates five common cost-cutting mistakes that health companies make:

- Cutting Back on Support Staff: sub-optimal reduction in support staff can make front-line caregivers less productive and increase treatment costs. Forcing clinicians to complete routine support functions prevents them from operating "at the top of their license." Far better to integrate lower-cost staff into more efficient care delivery that doesn't compromise quality.
- Underinvesting in Space and Equipment: "idle" space and equipment are less expensive than idle medical personnel, particularly high-cost specialists. Investing in facilities and equipment that increase caregiver productivity reduces overall costs.
- Focusing Narrowly on Procurement Prices: supply prices are only one component of supply cost. Supply choice and use patterns often exert more influence on a procedure's total cost. Cutting supply prices feels good, but frequently doesn't improve productivity or reduce costs.
- Maximizing Patient Throughput: increasing clinician patient loads only works if shorter-duration interactions do not worsen outcomes. This tactic often backfires. Less time with patients means less time to discover and implement better and less-costly care strategies.

Alternatively, spending more time with patients often improves engagement and leads to better outcomes at lower total cost.

- Failing to Benchmark and Standardize: variance in procedure performance, protocols and costs is evidence of sub-optimal performance. Reducing variance requires constant process improvement that eliminates waste and inefficiency. The result is better outcomes, higher quality and lower costs.

Effective cost reduction occurs in pursuit of higher-quality outcomes. "Mistakes" happen when health companies adjust expenses in isolation. With a full understanding of costs and outcomes for care episodes, clinicians and administrators "can work together to deliver the same or better outcomes with an overall lower-cost mix of personnel, purchased materials and equipment."

Hi-Yo Silver: Better Costing to the Rescue

All is not lost. Superior methodologies exist to pinpoint costs, optimize resources and boost productivity.

Measuring the costs and outcomes of care episodes is not rocket science. It's the logical response to marketplace demands for better, more affordable and personalized healthcare. The "art" of costing is balancing the precision of desired data with the effort required to generate it.

Ideal solutions combine actionable cost data for "objects" (products and services) generated systematically and efficiently. Two methodologies stand out:

- Activity-Based Costing (ABC): RCC and RVU are gross methodologies for allocating resources to objects (two levels). Neither approach measures the activities required to create "objects".

  To address this omission, ABC creates a third "activities" level to measure what actually occurs during the production process. It assigns indirect costs to objects based on the activities required to produce the object. It also assigns costs for the resources consumed by each activity in the production process.

  By "mapping" the relationships between resources, activities and objects, ABC assigns real costs to a company's products and services. In doing this, ABC enables productivity measurement and facilitates performance improvement.

- Natural Flow Costing (NFC): NFC expands upon beyond the three-level ABC model to accommodate the actual number of production levels (usually eight to twelve) an organization employs to create objects. For example, it details revenues and costs at the department level (pediatrics), the specialty level (neurosurgery), the procedure level (surgical puncture), the ancillary level (pathology), the physician level, the individual procedure level and so on.

  Aggregating this level of data, (usually from existing data sources) at multiple execution levels clarifies operating performance and facilitates targeted outlier analysis. It also enables cross-referencing by payor and outcomes. NFC provides real-cost and outcome data for entire episodes of care (the best metric for measuring performance). Consequently, NFC promotes efficient resource allocation, productivity improvement and profitability.

The University of Utah Embraces Costing

UNIVERSITY OF UTAH HEALTH CARE

A recent New York Times article explored how the University of Utah has engineered 0.5 percent annual cost declines in recent years. During the same period, academic centers nationally have experienced 2.9 percent annual increases.

Utah's secret? They've developed powerful cost-accounting and decision-support software that calculate treatment costs to the penny – the per-minute cost for ER time is 82 cents.

The software incorporates over 200 million cost elements and correlates with outcome measures, such as readmissions and procedure complications. It reveals opportunities for improving outcomes at lower costs. For example, Utah discovered rampant lab test ordering by residents. Excessive blood tests were making some patients anemic. Requiring residents to justify lab orders now saves $200,000 annually. Somewhere, Michael Porter is smiling

If Not Now…

America already spends enough on healthcare. Like Utah, organizations can reduce costs and deliver better healthcare. Fawn Weaver, the founder of "The Happy Wives Club," observed, "Happily ever-after isn't a fairy tale. It's a choice." Marrying costs with outcomes enables better medical decision-making, reduces errors, improves health outcomes and turbocharges productivity. It seems almost too good to be true. It's not. It's a choice.