

EXECUTIVE SUMMARY

WHAT IS DRIVING TOTAL COST OF CARE?

**An Analysis of Factors Influencing Total Cost
of Care in U.S. Healthcare Markets**

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■ ABOUT THE RESEARCH PARTNERS

Healthcare Financial Management Association

With more than 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. We help healthcare stakeholders achieve optimal results by creating and providing education, analysis, and practical tools and solutions. Our mission is to lead the financial management of health care.

Leavitt Partners

Leavitt Partners is a health care intelligence business. The firm helps clients successfully navigate the evolving role of value in health care by informing, advising, and convening industry leaders on value market analytics, alternative payment models, federal strategies, insurance market insights, and alliances. Through its family of businesses, the firm provides investment support, data and analytics, member-based alliances, and direct services to clients to support decision-making strategies in the value economy. For more information please visit [LeavittPartners.com](https://www.leavittpartners.com).

McManis Consulting

McManis Consulting provides research and management consulting services for clients who specialize in healthcare, financial services and technology and for public and quasi-public sector organizations involved in these fields.

For the healthcare industry, the firm works with a wide range of organizations:

- Hospitals and health systems
- Associations and industry groups
- Physician groups
- Clinically integrated networks
- Governmental and other policy organizations

Since 1964, the firm has successfully completed more than 3,000 assignments. Clients range from start-ups to industry leaders.

■ EXECUTIVE SUMMARY

In a combined quantitative and qualitative analysis of factors that may be influencing total cost of care in healthcare markets across the United States, researchers from the Healthcare Financial Management Association (HFMA), Leavitt Partners, and McManis Consulting found that:

- **The penetration of population-based value-based payment (VBP) models is not yet having an impact on curbing growth in total cost of care.** The efficacy of these models in reducing growth in total cost of care has not yet been proven, however, as even in markets where these models are more prevalent, most models do not yet incorporate sufficient financial incentives to impact care delivery significantly.
- **Although more time and evidence are needed to prove the efficacy of population-based VBP models, there are other models that may be more appropriate for different populations.** Alternative VBP models of interest to stakeholders interviewed for this study include episode-based payments, reference-based pricing, on-site health centers for employers and their employees, consumer-driven models tied to more effective transparency tools, and models that target the needs of specific patient populations.
- **The question of “what type” of competition may be more important than “how much” competition.** Lower-cost markets appear to benefit from competition among healthcare systems with well-organized provider networks and geographic coverage across their market. Health plan competition also appears to be a significant factor, especially with respect to encouraging innovation in payment models and plan design within a market.
- **Lower-cost markets also appear to benefit from organized mechanisms, including state-sponsored or endorsed reporting agencies and employer coalitions, for more transparent sharing of information on provider quality and costs.** Interviewees also believe that greater transparency of quality and cost information for consumers is necessary, while acknowledging that transparency tools that have been offered thus far have had limited impact.
- **Healthcare leaders across markets believe that further changes to payment and care delivery models are inevitable and will likely include value-based components.** In most markets, however, it is not yet clear what or who will be the catalyst to push further change.

Impact of Population-Based Value-Based Payment Models

A quantitative analysis of possible correlations between population-based VBP models and total cost of care found no statistically significant correlation during the period analyzed (2012-2014). A higher level of population-based VBP model penetration also had no statistically significant impact on quality outcomes.

In our qualitative analysis, several explanations for this lack of correlation emerged. They include:

- **The period studied was too early for effects on total cost of care to be realized.** Participation in programs such as the Medicare Shared Savings Program (MSSP) was just beginning during the 2012-2014 period of analysis, and reports of outcomes on performance under the MSSP model indicate that success in achieving shared savings often requires several years of participation in the program.
- **Few population-based VBP models offer significant incentives to manage total costs of care.** VBP contracts for most provider organizations interviewed for this study had upside risk only; very few organizations were yet taking on downside risk. Both health plans and provider organizations felt it was important to take an incremental approach to risk. The result, however, is that financial incentives are not in place for broad-scale changes to care delivery.
- **Incentives have not yet been aligned from the system level to the clinician level.** Across most provider organizations interviewed for this study, clinician compensation remains heavily reliant on productivity-based compensation. Within some physician practices, especially those focused on primary care, there was a sense that change was closer at hand and compensation metrics tied to quality, access, and patient panel size were being introduced.
- **Infrastructure costs can delay positive realization of a return on investment.** For organizations that are participating in population-based VBP models, the infrastructure costs for patient population analytics and care management can be significant and are likely to significantly offset any savings realized during early years in the models.

Given these considerations, the efficacy of population-based VBP models in containing growth in total cost of care has not yet been established. Financial incentives will have to strengthen considerably before the impact of these models can be proven.

Impact of Factors Related to Market Structure

The quantitative analysis identified 23 factors that had a statistically significant impact on variations in baseline total cost of care across local markets. Combined, these factors predicted 82 percent of the variation in baseline costs. The most significant factor in predicting baseline costs was the prevalence of chronic diseases within a local market. Other significant factors included hospital quality (including readmission rates and mortality rates), the percentage of costs related to inpatient care, factors relating to the physical environment, and socioeconomic conditions (including the prevalence of dual-eligible beneficiaries in the market and the proportion of individuals with insurance coverage). Cost of living also affected total cost of care, as a comparison of actual costs and standardized costs for the nine qualitative markets revealed.

These factors proved much less successful, however, in predicting variations in growth in total cost of care across local markets. Combined, they predicted just 27 percent of variation in growth, with the remaining 73 percent attributable to unknown factors. The significance of factors also shifted, with physical environment factors (including average daily maximum and minimum temperatures and metropolitan or micropolitan status) predicting more of the variation in cost growth than prevalence of chronic diseases.

The quantitative analysis also indicated that although health plan and hospital concentration had a statistically significant impact on predicting baseline total cost of care and growth in costs, the impact was relatively small compared to other factors. Market concentration could also have both negative and positive correlations with cost.

The qualitative analysis of nine markets also suggested that competition alone is not the answer: the question of “what type” of competition may be more important than “how much.” A comparison of the nine markets suggested that:

- **Costs were lower in markets with well-organized provider networks.** Sufficient consolidation had occurred in these markets to leave between two and four health systems with good geographic coverage competing within the market.

Physicians in these markets tended to be either employed by the health systems or be in close alignment with a system. Lower-cost markets also tended to have at least one integrated delivery system as a significant competitor in the market.

- **Markets that were less consolidated, or less aligned vertically, tended to be higher cost.** Independent specialty physician groups often competed directly with health systems in these markets, as did specialty surgical facilities or hospitals. Patient care also tended to be more vertically segmented in higher-cost markets, with higher, middle, and lower income groups receiving care from different provider networks.

The qualitative analysis also found that lower-cost markets had good mechanisms for sharing information among care purchasers. Organized employer coalitions or state reporting agencies dedicated to the exchange or public reporting of information on healthcare quality and costs were present in many of the lower-cost markets.

Other Findings

Other findings from the qualitative analysis indicate that:

- **Employers express concern about costs but are reluctant to adopt models that might be perceived as limiting employees' choice of providers.** As unemployment rates go down in most markets, employers are concerned about changing benefit designs that they see as important tools for the recruitment and retention of employees.
- **Payment pressures and pressures on physician practices continue to grow.** For most provider organizations in the nine qualitative study markets, government programs were paying for a steadily increasing percentage of patients. For physician practices, factors such as the costs of electronic health records and other technology, increasing administrative burdens, and pressures on payment rates were presenting significant challenges for small, independent physician practices.
- **The outlook for the Affordable Care Act is tenuous.** Several of the markets visited were not in Medicaid expansion states. The state exchanges in many of the markets were troubled, with high year-over-year premium increases and declining enrollments that affected risk pools for health plans on the exchanges.

Recommendations and Action Steps

Based on our findings, we recommend several key focuses moving forward that we believe could moderate growth in total cost of care.

- **Continue movement toward models that increase financial incentives to manage total cost of care and closely monitor the impacts of doing so.** Given our finding that VBP models may have penetrated *broadly* in some markets, but not *deeply* in most, we recommend that both government and commercial payers continue to experiment with models that increase incentives to make changes to care delivery models that could increase both the quality and cost-effectiveness of care. Experiments should continue with population-based VBP models but should not be confined exclusively to these models. It will be imperative to document the success or failure of VBP models in managing total cost of care to demonstrate the value of adopting these models more broadly.
- **Balance the benefits of competition with the benefits of integration.** Our qualitative research found that lower-cost markets had competition among a few health systems that were highly aligned with physician groups, whether employed or independent. We also found that that lower-cost markets had some degree of competition among health plans and that there was more innovation with payment and care delivery models in these markets.
- **Support more transparent sharing of information on healthcare cost and quality within markets.** Lower-cost markets in the qualitative study had organized mechanisms for the sharing of information on healthcare cost and quality, whether through employer coalitions, statewide reporting agencies, or both. Effective consumer transparency has proved more of a challenge, but there was widespread consensus that with the right tools and incentives, it could have a significant impact.

These recommendations have specific implications for policymakers, health plans, clinicians, health systems and hospitals, employers, and other community leaders. These implications are described in detail in the “Recommendations and Action Steps” section of the report.

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AN ANALYSIS OF FACTORS INFLUENCING TOTAL
COST OF CARE IN U.S. HEALTHCARE MARKETS**

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