Megatrends: Where healthcare is headed

“We’ve never seen a time when more trends are converging,” says Joel Sauer, vice president at MedAxiom Consulting. “These forces are having, or will soon have, a profound impact on everyone; from doctors to their patients to healthcare vendors,” he says. As a principal in MedAxiom Consulting, Sauer travels to healthcare organizations (HCOs) throughout North America, guiding them on how the changes in the healthcare environment will affect their ability to serve patients, while remaining profitable. “Virtually every area of what doctors do is going to change over the next several years, ranging from the number of patients they see, to how those patients are diagnosed and treated, to how they pay for that treatment,” Sauer notes. In his discussions with doctors, practice managers and HCOs, Sauer brings up eight so-called “megatrends,” overarching considerations that will direct the nature of healthcare:

1. CONCEPT OF VALUE:

Value, Sauer says, has embedded itself deeply in the healthcare vernacular, being defined as outcomes divided by cost. The “holy grail,” he says is better health, a better patient experience, all at a lower cost. “The entire paradigm has changed from ‘come in when you’re sick and I’ll treat you,’ to ‘I’m responsible for helping to keep you well.’” He agrees that was the initial goal of Health Maintenance Organizations, but says the experience merely “proved that health insurance companies are lousy at managing health care; doctors need to manage patients.”

Under the new paradigm, he says, echoes and nuclear studies will be bundled as part of the overall treatment, meaning the individual tests will no longer be a revenue generator, but an expense. “We’re still trying to figure it out, and get our arms around these issues,” Sauer adds.

2. CHANGING PAYMENT PARADIGM:

“We know that we’re shifting from volume to value, where value is measured as outcome over cost. For the first time, we’re not only talking about doing what’s best, but at what cost, and that’s a monstrous paradigm change,” Sauer says. In terms of reimbursement, he says that while Congress has repeatedly avoided huge cuts in the Sustainable Growth Rate (SGR), the increases granted in reimbursement fail to cover the added annual expenses in running a practice; Sauer notes the increased reimbursements often cover less than one-quarter of the added costs. “And when you look at nuclear and echoes, reimbursements for those tests have dropped over 36 percent over the last five years. They were a big profit driver for cardiology practices, and it’s been waylaid.”

As noted above, consumers are paying more of their bills, he adds, saying Health Savings Accounts (HSAs) and high-deductible plans are pushing costs to consumers. “And when you begin talking about ACOs, now you’ll see where we’ll get radical on how to pay for health care,” Sauer says. “Everyone knows we’re headed away from fee-for-service (FFS), and moving toward some more global payment mechanism, centered around populations, or bundled around diagnoses like congestive heart failure (CHF), or diabetes. Under the current system, waste is physician compensation; it becomes a cost under a global payment environment.”

Sauer focuses on CHF, saying it incurs a disproportionate share of expenses in the current healthcare system. The Center for Medicare and Medicaid Services (CMS) is working to reduce readmission rates; nationally, more than one-fifth of all CHF patients are readmitted within 30 days after initial discharge. “CMS says this costs billions of dollars, so if you’re in the bottom quartile of the readmission rates, you’re going to get one percent reimbursement penalty this year that goes to two percent penalty next year. If you’re in the top quartile, you’ll get a one percent bonus that rises to two percent. And that’s true for every Medicare patient you see – not just the CHF patients. This is huge, and most hospitals aren’t ready to deal with it.”

Part of the problem, he says, is that hospitals keep doctors out of financial discussions; he argues that they are needed
there more than ever before. “By most estimations, doctors have a direct influence on about 96 percent of health care costs, and yet they’re left out of the cost side of the equation. Some hospital lawyers say you can’t share financial information with doctors. How can you not have them at the table when they’re the primary cost driver?”

3. SPENDING ON MEDICAL PROCEDURES:

Sauer says spending on health care continues to increase, but notes the rate of increase is decreasing slightly. “It’s like saying the speed has decreased from traveling by rocket to traveling by an F-10,” he says. While the rate of increase has declined slightly, down to a 7.5 percent growth rate in 2012 from the average of 10-12 percent over past 15 years, nothing in the healthcare system has changed dramatically in the past year that would serve as a direct cause of the reduction. Sauer questions whether the spending slowdown is largely because of the expiration of patents on high-volume, high-profit “blockbuster” drugs like Lipitor and Xanax, and those drugs being available on a generic basis at lower cost to patients.

“The amount Americans spend on health care is still dramatically higher than it should be, despite the current downward pressures on cost,” Sauer says. “We have to fundamentally reduce spending. What we’ve been doing over the past 10 years isn’t working. We have to do something more drastic, which is why we’re seeing Federal legislation like the Affordable Care Act, and moves toward things like Accountable Care Organizations (ACOs) and bundled payments.”

Ultimately, he says, the driver toward lower costs will be the consumer, not healthcare providers. “Ten thousand baby boomers are entering the high-use category every day. They’re not going to change their demands as consumers just because they’re 65. They’ll expect more than did their parents, especially since they’ll be paying a lot more of the tab,” Sauer says. He cites numbers from the Bureau of Economic Analysis which say that by 2019, consumers will pay for more than half the cost of their health care, the first time that number will have been that high since before World War II.

“They’ll expect more out of us as an industry. And since they’re comfortable with computers, they won’t tolerate things on pieces of paper. They’ll have expectations they can access everything online; they’ll want to schedule appointments and refill their prescriptions.”

4. GOVERNMENT INCREASES COMPLIANCE ISSUE FUNDING:

The Department of Health and Human Services reports that through its overpayment and fraud fighting initiatives, such as the Recovery Audit Contractor (RAC) program, it recovers $15 for every dollar it spends. Sauer says that in 2012, more than four billion dollars were paid back through things like RACs, cath lab prepayment audits and ICD implant audits. “They’re not going to stop that. They’re going to find new places to take back money,” he states, saying that private third-party payers are engaged in similar efforts through radiology benefit managers (RBMs).

5. CONSOLIDATION/INTEGRATION:

Data reveals that fully two-thirds (67 percent) of the cardiology groups aligned with MedAxiom are now integrated with larger HCOs. Sauer says additional numbers show that 47 percent of all physicians nationwide, likewise, now work in an employed model. “With more than 6,000 cardiology members, we believe we’re representative of the larger cardiology community,” Sauer says, noting that a 2012 survey by the search firm Merritt Hawkins & Associates predicts that 75 percent of all physicians will be employed in hospitals by 2014. In addition, data shows doctors employed in integrated settings tend to earn more.

“The signs are everywhere and they’re unmistakable,” says Sauer. “The Cleveland Clinic has just announced a five-year quality initiative with Community Health System, and in Texas, Baylor Health has merged with Scott & White. It’s not just hospitals buying doctors; everybody’s believing they need to be bigger and broader in this new world.” Sauer adds that there are multiple forms an alignment can take that don’t necessarily result in doctors being employed by larger HCOs, but he says Federal laws are stacked against that model. “The Stark Act is only one example, plus you have initiatives against fraud and abuse and anti-kickback. The government has it pretty wrapped up,” he says.
6. DEVELOPMENT OF HEALTH CARE TEAMS:

The growing focus on involving teams of professionals in all aspects of care, including the use of mid-levels and medical assistants, is emerging as a “best practice” for assuring comprehensive and proactive care. A great example of this is the Patient-Centered Medical Home in primary care. Ironically, Sauer says, “What we’re doing in human health care is where veterinarians have been for years. My vet has been extremely good at making sure our dogs come in for regular heartworm checks, vaccinations and the like. Ob/Gyn practices adopted this early, now the rest of us are catching up.”

Sauer says good software is mandatory to make the care team model work effectively, but it also takes good people. “We need everyone working at the top of their license or training, because we can’t afford to have them working and doing something that someone at a lower pay grade can do.” Today’s engaged and demanding consumers, he says, won’t pay for that and frankly the country can’t afford it. “The more we have computers and assistive devices, the more we can control costs, while increasing the quality and outcomes of care.”

7. DATA MANAGEMENT:

“In the era of Big Data, there’s no place to hide. So much public data is available out there, you won’t be able to have substandard quality and not have anyone know about it,” Sauer says.

He says sites like Consumer Reports, Medicare’s Physician Compare, WhyNotTheBest.org, even Angie’s List contain reports on the comparative performance and costs of doctors and hospitals. “The scary part is it doesn’t matter if the data are right. Consumers are using it anyway. You can’t simply say it’s junk and ignore it; if it’s junk, fix it. That being said, I don’t accept that it’s all junk. It’s clear there is some fire where we’re seeing all the smoke. As professionals, we need to embrace and get the data clean so it’s an accurate reflection of how we’re doing. As we’ve seen, if we don’t, someone will do it for us.”

The availability of data is key to the change in the approach today’s patients take in assuming a more active role in managing their healthcare. “Our parents might stay under the old ‘the doctor says’ mentality. Today’s generation comes in with 30 pages they’ve downloaded from the Internet. They’re more demanding; they want to know if you’re certified, and from where you received that certification. They want to know why you’re ordering a test and what you’ll do with the results,” Sauer says.

At the same time, Sauer notes that healthcare is beginning to use data, through the rapid evolution of business intelligence (BI) software, to better help manage care. For instance, he says United Health Group and Wellpoint are jointly developing BI software to help predict which patients are most likely to be affected by diabetes, CHF and medication compliance issues. “They’re using the software to predict who’s most likely not to get scripts filled, which will most likely result in a bad outcome.” Additional advancements are being made in the use of biomarkers, such as troponin levels, can help solve the challenge of when to safely send patients home from the emergency department. “In the new payment paradigm, admitting a patient will become a cost, not a revenue generator,” says Sauer. “Plus, it’s not good for the patient, so this is a very good thing.”

8. “GRAYING” OF CARDIOLOGY:

It’s not only the number of patients who are getting older, Sauer says; he also notes a looming physician shortage. Data from MedAxiom, the American Medical Association and the American College of Cardiology show that cardiologists will be harder to find in the next 10 years. “They’re leaving faster than we can put them in,” Sauer says. “Here’s the issue. None of the doctors who’ve been practicing for decades want to take calls at night or weekends. They all want to work during the day. So, if you bring in more cardiologists to handle only nights and weekends, you’re going to have an overpopulation of doctors in your practice.” Sauer cites the MedAxiom study, which reported that 22 percent of cardiologists are over the age of 60, and an ACC study that predicts a shortage of 16,000 cardiologists nationwide by 2025.