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The Ignored Healthcare Solution: Reward Cognitive Effort

The U.S. health care system is a usage-driven health care system. The only solution is to create a patient-care driven system where the physicians and plans partner to create real savings by rewarding the providers.

During the past decade a tremendous amount of focus has been placed on the increasing cost of health care. National health expenditures have skyrocketed and are projected to increase to $4.031 trillion by 2015[1]. These values represent 13.8%, 16.0%, and 20.0% of the Gross Domestic Product (GDP) of the United States, respectively. There are a variety of reasons for the increase in costs, and just as many proposals for solutions to control the increase. However, the proposals ignore the most promising solution, which is to reward the cognitive efforts of physicians and their clinical staff.

We all know the market reasons for soaring health care costs:

- The population is aging.
- The population is demanding more health care services; more services are now provided per patient than in the past.
- Technology has yielded advancements in both diagnostic and therapeutic services, often at an increased price.
- The incidence of chronic diseases, and patients with multiple chronic diseases, has increased.
- There may be too many health care facilities across the U.S.

We believe one of the biggest contributors to rising health care costs is being completely ignored – the fact that physicians are not being rewarded for their cognitive services. Because of this, they are being forced to look at other avenues to generate income and are choosing to invest in ancillary services, such as PET, CT and MRI imaging centers, and other joint ventures to make up for lack of reimbursement. This has created an over-abundance of ancillary services and is driving the cost of patient testing up. This, in turn, drives up the cost of Medicare and private pay health insurance as well as other out-of-pocket payments patients have to contribute.

In our opinion, the solution to rising health care costs is quite simple. So simple that no one is looking at the forest through the trees: Simply revamp the system to place emphasis on rewarding the cognitive efforts of all physicians in both the hospital setting and the private practice sector. The overall outcome would be a significant cost decrease to the system due to the appropriate management of patients – resulting in lower numbers of visits to the emergency room and the hospital in general as well as shorter hospital stays. It would also enable millions of

[1] National Health Expenditure Data, National Health Statistics Group, Office of the Actuary, Centers for Medicare & Medicaid Services

Americans to receive affordable health care coverage. How many times have we heard the comment that physicians can only spend 10 minutes with a patient and spend 20 minutes filling out paperwork?

In order for this effort to be successful and not result in a cost increase to the system, we believe it would need to be married simultaneously with the reduction in profits of ancillary services – to include hospitals, private offices and free-standing centers. Reducing these excess profits from ancillary business would discourage physicians from entering into future ancillary revenue deals.

Did you know? In many markets, hospitals are once again finding themselves employing the physicians and paying up to 30% of their compensation with ancillary profits. Look also at all the not-for-profit cancer centers in the U.S. that have been built with donor's money. Have their patient care and treatment costs decreased? No, they have not. This cost-saving measure has been attempted with the Congress mandating that all profits be stripped from cancer drugs. This was almost a success but CMS set up a payment system to encourage using expensive drugs, and they did not install enough payment in the services to encourage the physician to spend more time with the patient. It has been discussed that the cancer specialty finds that their time limitations with patients results in more unnecessary treatments. It is easier to say yes to a patient demand than spend one hour explaining why the end-of-life treatments may not be appropriate.

We believe the savings will be approximately 40% right off the top. With all overutilization, etc., there could be another 20% savings. Take 10% of the savings and add the dollars to the physician services. End the business that visits are bundled in procedures and surgery. If a visit is provided, pay for it. The 30% savings will reduce health care cost enough to make it affordable for the 40 million uninsured Americans. Pay for Performance will occur on all fronts of the health care arena. Physician compensation will increase, thus there will be a demand for the brightest to choose medical school over Wall street.

Payment for cognitive services is directly correlated with patient care while the profits on ancillary services have little direct correlation. Furthermore, ancillary services are reimbursed differently in different settings. Outpatient services are frequently reimbursed by commercial payers using a percentage of charge methodology while the same services are reimbursed in the physician office setting using a fee schedule methodology. This makes no sense at all. For hospitals, its just bill a higher charge to receive a higher payment based on the charge-to-payment methodology.

Why place an emphasis on rewarding cognitive efforts? Currently many cognitive services are unrecognized in the fee-for-service reimbursement system. CMS has attempted to pay for performance with demonstration projects that end up accomplishing no real savings. Few evaluation and management services are reimbursed when they do not involve direct face-to-face interaction between the physician and the patient. Consider the following:

- Joint collaboration between physician specialists are not reimbursed, even when the physicians are discussing the care of a single patient.
- Coordination of care between physicians is not reimbursed, therefore non-existent.
- Physician communication with patients via phone and e-mail is not reimbursed.

- Ordering and review of diagnostic tests may not be reimbursed if it occurs outside of the patient visit.
- Patient education conducted by physician employees is not reimbursed.
- Family counseling is not reimbursed.
- Psychosocial services related to an illness are frequently not reimbursed.
- Nutrition counseling is not reimbursed.
- Chronic care management is reimbursed in the course of the patient visit; however, frequent visits are often targets for payer audits.

It has been proven that follow-up on Medicare patients to determine if they are taking their medications is a real cost-saving measure. The lack of reimbursement drives physicians to both minimize these activities and to incur additional costs (through the hiring of triage nurses, for instance). If physicians were reimbursed to provide these services, the result would be greater quality of care, avoidance of duplication of services, and better patient outcomes.

Here is an example. If a physician is compensated for treatment planning services, the compensation for those services should be sufficient to enable the physician to evaluate the value of various treatment options. The physician would need the time required to consider which treatment options would yield the same outcome for the least expense, and that time would be compensated. Payment for cognitive services will be most effective when combined with physician accountability for the value of the services rendered to a patient. Value provides the framework and boundaries within which the physician can and should operate.

Currently physicians control the costs of health care through the power of their pen. They have little incentive to control costs because they either: 1) have no financial interests whatsoever in the cost or reimbursement of the services they order, or 2) have overriding financial interests in both the cost *and* reimbursement of the services they order.

This needs to change.

Does it make sense to decrease a payment on an office visit if the physician spends time with the patient and offers a comprehensive review and exam and the patient remains stable – which is a lower level decision? The physician should be rewarded with a higher payment by taking the time to keep the patient stable. What currently happens are inappropriate audits that demand refunds for a physician's efficiency.

In closing, we propose the solution to controlling rising health care costs is this: reward the cognitive efforts of physicians while eliminating ancillary profits and increasing physician accountability. Implementing this solution will be a difficult, but not insurmountable, challenge. Not only will it cut costs in the long run, it will enable millions of Americans to have affordable health care coverage. We encourage you to embrace this solution and work together with us to meet the challenge.