The Forgotten Physician

Devorah Goldman

America’s doctors are in a bind. A variety of policy changes in recent decades have created new pressures for the profession, and physicians appear to be feeling the strain. Nearly 80% report symptoms of “physician burnout,” a problem that has become a catchphrase in medical journals, and 62% are pessimistic about the future of medicine. The profession has one of the highest rates of suicide in the U.S. (at an average of up to 400 a year, it’s more than double the rate of the general population), and multiple studies have demonstrated that doctors suffering from burnout are far more likely to make major medical errors.

These trends also seem tied to a looming doctor shortage. According to a recent study, nearly one in five doctors intends to reduce clinical hours in the next year, and more than 40% of currently active physicians will reach retirement age within the next decade. Meanwhile, the number of older Americans, who will likely need more health care, is expected to double by 2040. The Association of American Medical Colleges has estimated we may be short over 120,000 physicians by 2030, while a study in the Journal of the American College of Surgeons predicts a deficit of up to 214,000 doctors by 2025.

Policymakers have been responding: The recently introduced Resident Physician Shortage Reduction Act would add 15,000 medical-residency spots over five years, lifting a cap that has been in place since 1997. Similarly, the Opioid Workforce Act, introduced in 2018, would create 1,000 new Medicare-supported residency positions to train doctors in addiction medicine and related fields. The federal government has long supported residency training, spending around $16 billion on graduate medical education in 2015.

Devorah Goldman is an assistant editor at National Affairs.
Medical schools have also taken steps to improve their numbers: New York University made headlines in August 2018 when it announced that it would be offering free tuition to all its medical students, regardless of need or merit, making it the only top-10 medical school to do so. School officials described the initiative as a “moral imperative” designed to address “both physician shortages and diversity.” Other schools have reduced the duration of their programs from four years to three in a bid to make medical education more appealing. While free training or shorter programs may attract more students, they do not address key deterrents to remaining in medicine, which today go far beyond meeting tuition payments or surviving tough residencies.

Debates over health care understandably tend to revolve around how to get the most affordable care to the most people. In their attempts to achieve quality and value through regulation, however, policymakers have blamed doctors for rising health-care costs, forced them to accept less control over their own pricing, robbed them of autonomy in making medical decisions, and compressed the time they can spend on patient care with onerous (and sometimes dangerous) data-entry requirements—all while expecting better health outcomes.

While drug companies, insurers, and lawmakers all have a voice in the policymaking process, groups representing doctors and medical schools attract far less attention, at least in part because doctors are still doing well by many measures (though their incomes have steadily declined or stagnated for decades). Though their work can be draining, their plight might not seem especially wretched when compared to that of low-income patients. But high-quality health services depend upon high-quality providers, and in discussions of quality and value in medicine, it is vital to remember that both quality and value are grounded in the doctor-patient relationship. Our policies should reflect that, when determining what is best for patients, the health and well-being of physicians matter too.

**Defining Doctors**

Ronald Dworkin has written in these pages about the evolving identity of the American physician, from gentleman-doctor to benefactor to technician to scientist. In recent years, a combination of new laws and technologies have again redefined the doctor, this time as a sort of data-entry clerk. As Dr. Robert Wachter and health-policy consultant
Jeff Goldsmith put it in the *Harvard Business Review*, “Only in health care, it seems, could we find a way to ‘automate’ that ended up adding staff and costs!”

A taste of what today’s doctors must contend with can be found on the “Official Website of the Office of the National Coordinator for Health Information Technology,” one of several government sites devoted to explaining Medicare to physicians:

Regardless of whether you’re reporting on the Advancing Care Information Objectives and Measures, or on the Advancing Care Information Transition Objectives and Measures, using certified [Medicare Electronic Health Records (EHR)] technology can aid you in the process. It may help you attain the 25 points allocated to Advancing Care Information reporting as part of the [Merit-based Incentive Payment System (MIPS)] program. Using a certified EHR technology is required for reporting Advancing Care Information measures for most clinicians…and it may make your overall MIPS reporting easier.

The jargon-laden instructions go on to provide links to several different webpages that discuss exceptions to these rules, explain the various technologies mentioned, and go into greater detail about MIPS itself. These do not include CMS’s many instructions for Medicare reporting and compensation, which can be found on the CMS website, or those provided on Medicare.gov, which is separate from CMS.gov. Given the complexity of reporting requirements, it isn’t surprising that physicians have begun to hire medical scribes, additional administrators, or consultants specially trained in “health IT” to navigate Medicare’s reimbursement system. The costs of these newly created positions are not covered by Medicare: Doctors must pay for the services out of pocket or spend their working hours taking endless notes and filling out forms instead of caring for patients. One large-scale survey in 2016 found that, of 17,236 physicians who responded, only 14% said “they had the time they needed to provide the highest standards of care.”

Much of the stress physicians feel comes down to the attempt to transform medicine, in Dworkin’s words, into a “foolproof” profession. Insurance companies and the government, not doctors, increasingly determine which tests are medically necessary and what they ought to
cost. While there are undoubtedly abuses within the medical profession, much of the practice of medicine entails prudence and experience that is difficult to systematize. But doctors seem to have been almost forgotten in debates about medical care, particularly with regard to what quality means in terms of time spent with patients, tests recommended, and diagnoses offered.

HOW WE GOT HERE

In 1997, Congress set the stage for nearly two decades of instability by approving the Sustainable Growth Rate formula as part of the Balanced Budget Act. The SGR tied Medicare Part B payment rates to the overall growth in GDP, which seemed reasonable at the time, as Part B spending had grown disproportionately. The formula proved woefully flawed, however: Until SGR was repealed in 2015, Congress overruled its own system 17 times to avoid drastically slashing physician payments to meet “target” Medicare expenditures based on the GDP. In 2011, for instance, the cuts would have amounted to over 29%, at which point over 40% of physicians considered refusing to accept new Medicare patients.

The SGR imposed across-the-board cuts on Medicare rates regardless of the performance of individual doctors or groups. Deferring the cuts also had a cumulative effect: To minimize the budgetary impact of the annual “doc fixes,” Congress increased the reductions to make up for the deferral of prior years. Before it was finally repealed, doctors had faced potential cuts of 20% to 30% of their Medicare-based income for years, making it difficult for them to plan for the future. The problem was exacerbated by recessions in the early and late 2000s, during which the GDP contracted while health-care costs continued to rise. As it turned out, the disparity between the GDP and Part B growth rates reflected trends that neither Congress nor doctors had a clear handle on.

The rise in Part B costs that eventually resulted in SGR rested on a number of factors, at least two of which are frequently overlooked. The first concerns the types of services covered by Part A and Part B, the two components of “traditional” Medicare. Part A mainly covers the cost of inpatient hospital care for seniors or disabled individuals, and is a straightforward entitlement funded mostly by payroll taxes; Part B covers physician services, outpatient hospital care, and certain prescription drugs administered in an outpatient setting. Part B is also voluntary and is funded through a combination of premiums paid by beneficiaries,
general revenues, and other sources. It was intended and is still widely understood to cover mainly conventional non-hospital care, such as a regular doctor’s appointment, though that has changed over time.

This structure had unforeseen consequences. As Chris Pope explained in this journal, hospitals were transformed following the launch of Medicare “from being institutions of last resort to all-purpose providers of medical care. While the Consumer Price Index increased by 89% from 1966 to 1976, hospital costs rose by 345%.” Hospital insurance provided by Medicare Part A also “increased the number of hospital patient days reimbursed according to cost by 75%.”

This is because Congress initially adopted the private health-insurance sector’s “retrospective cost-based reimbursement” system to pay for hospital services. From 1965 through 1983, Medicare reimbursed hospitals on a per diem basis, and individual hospitals had mostly free reign to calculate the costs of inpatient treatment. The “cost reports” filed by hospitals were meant to reflect the actual price of hospital services, but as Pope noted, Medicare reimbursements were also used to “bankroll major capital investments, expansions of capacity, staffing, or technology.” Seemingly endless government funds, combined with a lack of accountability, incentivized hospitals to spend with abandon, and from 1970 to 1980, Medicare hospital payments increased by 88%.

In response, Congress sought to curtail Medicare’s hospital payments by reformulating Part A’s payment structure. Instead of paying for a set of services determined by the hospitals, Congress tasked CMS (then known as the Health Care Financing Administration) with implementing a prospective payment system (PPS): a per-case reimbursement mechanism under which Medicare would pay a flat rate based on a patient’s diagnosis. With this system, which Congress approved in 1983, inpatient hospital cases were divided into categories called diagnosis-related groups (DRGs). Medicare would decide how much a particular diagnosis ought to cost based on the DRG coding system, which took factors such as geography and age into account. Hospitals were paid according to this code, regardless of how much a given hospital might end up spending on a patient. This was effective in reducing Medicare hospital payments, which declined by 52% between 1985 and 1990, and again by 37% between 1990 and 1995.

At the time, Part B had a less rigid payment structure, so hospitals were incentivized to shift services to Part B where they could. Many
procedures that had previously required inpatient admission, such as cataract removals or colonoscopies, were increasingly performed on an outpatient basis. The practice arrangements of many hospital-based physicians, such as radiologists, anesthesiologists, and pathologists, were restructured into contractual relationships or private settings to remove these expenditures from overall hospital costs.

The growth of managed care, most commonly in the form of health-maintenance organizations, also incentivized hospitals to cut costs. The Health Maintenance Organization Act of 1973 spurred a major expansion of HMOs, which had long been opposed by many in the medical establishment, in an attempt to constrain rising health-care costs. It authorized $375 million to support the creation and expansion of HMOs, required employers with 25 or more employees to offer an HMO option if they already provided health insurance to their employees, and overrode state laws that restricted the establishment of HMO plans. As a report from the National Council on Disability explains, “The purpose of the legislation was to stimulate greater competition within health care markets by developing outpatient alternatives to expensive hospital-based treatment” (emphasis added).

By 1983, CMS had approved Medicare payments for some 450 procedures performed in freestanding, outpatient, ambulatory surgery centers; by 1992, that number had risen to 2,400. The total number of such procedures paid for by Medicare grew from 377,000 in 1983 to 2.5 million in 1991. Most of this outpatient care is charged to Part B, not Part A. As with PPS, the expansion of managed care contributed to the decrease in Part A’s growth and the rise in Part B’s costs.

This rise was significant. Between 1978 and 1987, Medicare physician spending per beneficiary had grown by an annual compound rate of 15%. By the late ’80s, physician expenditures were increasing at more than double the rate of hospital expenditures. But many lawmakers seemed to miss the reasons why (or chose to ignore them). Beyond the expansion of managed care and ambulatory outpatient centers, hospitals also began to purchase private physician practices and furnish them with equipment to perform additional procedures, which also contributed to the transfer of charges from Part A to Part B. By 1990, less than half of hospital surgeries were performed on an inpatient basis. As a recent report to Congress by the Medicare Payment Advisory Commission noted, outpatient spending in 2016 “rose by almost $3 billion because of
rapid growth in Part B drug spending and an increase in physician services billed as hospital outpatient services. This increase in part reflects hospitals’ acquisition of physician practices” (emphasis added).

These trends were scarcely discussed in the lead-up to SGR. Increased billing for procedures and surgeries under Part B was widely understood to be an indication that private physicians were taking advantage of Medicare for personal gain — and no doubt some were. But a large portion of this increase was due to the simple fact that hospitals had shifted services to outpatient facilities, including private practices.

A separate, important contributing factor has been the growth in expensive and complicated medical equipment, which has essentially become its own industry. “Imaging centers,” which offer procedures such as CAT scans, PET scans, and MRIs, bill for a variety of expensive, discrete services under Medicare’s reimbursement code. Nuclear medicine, for example, which involves the injection of radioactive materials prior to imaging procedures, is a costly component of such scans. Quest Diagnostics, LabCorp, Sunrise, and other groups are huge, publicly traded companies that perform laboratory tests, which are often billed to Part B. Over the years, Part B payments have also come to include approved non-physician services such as speech therapy, chiropractic treatment, and social work. Orthopedic shoes, ambulance transport, and medical equipment are also covered by Part B.

Medicare Part B reimbursements are not simply physician fees; the payments go toward services that are ancillary to or entirely separate from doctors’ actual tasks. From 1981 to 1986, rising physician fees accounted for only about 6% of the total growth in Part B expenditures per enrollee. And during a freeze in Part B payment rates from 1983 to 1986, total spending still increased by nearly 30%. Almost 75% of this growth was attributed to a greater number of discrete services per beneficiary and the aforementioned shift of services from hospitals to non-hospital physicians.

MEDICARE’S ABANDONED PROMISE

These trends led to problems for doctors, who soon became the focus of policymakers’ attention. As Rick Mayes and Robert Berenson document in Medicare Prospective Payment and the Shaping of U.S. Health Care, Medicare won the support of physicians based on the understanding that doctors would have substantial say over government reimbursement
rates. But this soon changed. Beginning in the 1970s, Congress launched a series of initiatives designed to tamp down Part B payments, resulting in doctors’ diminished ability to determine charges for their own services. In time, the medical business model was transformed, and Medicare, rather than doctors, increasingly set standard medical-billing rates.

It is important to understand just how much these policies undermined longstanding efforts by the American Medical Association and other groups to maintain physician autonomy. Following President Harry Truman’s election in 1948, the AMA launched a vigorous and ultimately successful campaign against national health insurance. Its combination of press attacks, pamphlets, and lobbying laid the matter to rest for the better part of two decades, through both the Eisenhower and Kennedy presidencies.

It wasn’t until after President Lyndon Johnson’s landslide victory in 1964 that Medicare seemed likely to pass, but not without key conditions. To assuage the concerns of the AMA, the bill included a number of provisions that created buffers between physicians and government. As Dr. Philip Lee and professor Richard Culbertson noted in a 1996 issue of the *Health Care Financing Review*, “Congress also adopted a payment method designed to attract physicians, permitting them to bill what they normally charged their privately insured patients, the ‘customary, prevailing, and reasonable’ (CPR) charge…. In addition, physicians were allowed to bill their patients directly through the practice of balance billing, which allowed them to collect more than Medicare’s reasonable charge.”

Medicare also included the assurance that “nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.”

In short, doctors were promised a degree of autonomy that simply did not last. In 1971, President Nixon imposed wage and price controls on the general economy, but particularly targeted the health industry. Fee increases were strictly limited in medical care, which was the last segment of the economy to remain subject to these controls; they were finally lifted in 1974. In 1972, Professional Standards Review Organizations were established as part of the Social Security Act, and were charged in part with determining whether items charged to Medicare were “medically necessary.” While these organizations mainly
affected hospitals rather than private physicians, they presented the first attempt to control the “appropriateness and quality of care” delivered to Medicare beneficiaries, and were the first in a series of federal initiatives that directly undermined the judgment of individual physicians.

In 1975, Congress tried to modestly limit the incentives for physicians to raise their prices by establishing the Medicare Economic Index. The MEI was meant to restrain the annual growth of physicians’ “prevailing charges” by re-adjusting them according to overall rates of inflation. This was somewhat effective in curtailing increased charges, but, as Mayes and Berenson explain, it also “created an extremely complicated fee schedule, with some services constrained by prevailing charge limits and others not so constrained.” While physicians could still raise their general prices, they began to receive far less in Medicare-allowed payments. This broke the link between physicians’ actual charges serving as a guide for Medicare payment rates. Among other issues, it allowed policymaking preferences to creep into what was meant to be a neutral pricing tool; for example, the fee schedule created financial incentives for rural physicians and family doctors, while essentially imposing a “special tax” on urban and certain specialty physicians. This problem was exacerbated by the introduction of DRGs in 1983. In addition to dramatically restructuring financial incentives for hospitals, it also imposed a top-down, formula-based payment system that seemed counter to the promises made by early Medicare proponents.

In 1984, as hospitals were increasingly outsourcing their services to Part B, Congress authorized a 15-month freeze on Medicare Part B payment rates that was later extended to around two years. But despite the fee freeze, as a 1989 study published in *Health Affairs* found, “the program and its beneficiaries were spending 29.5 percent more ($582 versus $450) for physician services by 1986 than was the case three years earlier…. The major spending increases were for surgery and diagnostic tests.” This is at least partly attributable to the re-alignment of inpatient and outpatient services, and to the combination of new diagnostic imaging tests and billing codes.

Also in 1984, Congress established the Participating Physician and Supplies Program (PAR), which offered physicians a deal. It presented the first attempt to directly transfer control of prices or fees from physicians to the government. Until PAR, after seeing a Medicare Part B beneficiary, physicians could write up a bill and send it either directly to
the patient or to Medicare. If the former, the patient would be responsible for full payment, but could file a claim and expect to be reimbursed a certain percentage by Medicare. Patients would still be responsible for paying charges in excess of Medicare-approved payments. The difference is often referred to as a “balance bill.”

Under the PAR, physicians would agree to accept assignment (the Medicare-approved charge as payment in full) on all claims in exchange for expedited claims processing and a direct payment from Medicare (rather than from patients). They would also be listed in a directory available to beneficiaries, a form of advertising. Last, they would be permitted to raise their submitted charges during the freeze while others could not (though for this they traded their ability to determine payments later).

Many physicians found this proposal offensive; according to the 1987 Report to Congress by the Physician Payment Review Commission, 80% of the physicians who had initially refused to participate in PAR believed doctors should always have the right to set their own prices. Many also felt they were being strong-armed into accepting short-term financial benefits during what seemed like a punitive fee freeze. Nevertheless, many chose to participate, and by January 1992, over 52% of practitioners had signed participation agreements.

Despite these constraints on physician autonomy, Part B outlays continued to grow, increasing from $10.1 billion in 1980 to $41.3 billion in 1990. And so the restraints continued, notably in 1986 with the Omnibus Budget Reconciliation Act, which placed limits on the amounts even non-participating physicians (meaning those who had not signed onto the PAR system) could charge above Medicare-approved prices.

In 1989, Congress effectively removed control of Medicare fees from the medical profession with a mandated Medicare fee schedule. It applied charge limits to all physician services, based annual fee updates on a “target rate of increase,” and increased federal support for clinical effectiveness research. According to the HCFA’s administrator at the time, Gail Wilensky, the relative values employed by the new fee schedule and the related expenditure targets were extremely difficult to implement. Once this system took effect in 1992, however, the results were profound. For the first time, Medicare was able to regulate both the price of and the volume of spending on physician services.

Even before SGR’s implementation in 1997, then, Medicare had increasingly moved to limit physician discretion in clinical and economic
matters. The SGR went further, however, by automatically mandating a reduction in doctors’ fees (previous measures had allowed for limited increases based on factors such as the cost of living). This set off chaos in the form of 17 fevered, last-minute votes to keep physician payments at acceptable levels.

This pattern finally changed in 2015 with the passage of the Medicare Access and CHIP Reauthorization Act (MACRA), which repealed SGR. The repeal ensured five years of stable annual fee increases of 0.5%, for which the medical community seemed grateful. This reprieve merely served as a transition period for a new system, however, which would add new rules that further complicated the lives of physicians.

**AN INCONVENIENT TECHNOLOGY**

The new challenges introduced by MACRA were linked to the Health Information Technology for Economic and Clinical Health (HiTech) Act of 2009, which had also created layers of requirements for hospitals and physician practices. Passed as part of President Obama’s 2009 stimulus bill, it “propose[d] the meaningful use of interoperable electronic health records throughout the United States health care delivery system as a critical national goal.”

Meaningful use is defined in the law “by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.”

The history of electronic health records and meaningful use is a sorry one. For years, EHR vendors spent millions in lobbying for legislation that would incentivize or compel the medical industry to purchase their products, and the HiTech Act has been a boon for them. A 2013 report from the *New York Times* noted that “Glen E. Tullman, until recently the chief executive of Allscripts, was health technology adviser to the 2008 Obama campaign. As CEO of Allscripts, he visited the White House no fewer than seven times after President Obama took office in 2009, according to White House records.” Since the law’s passage, revenues for some of the main vendors have soared: Sales at Allscripts, for example, rose from $548 million in 2009 to over $1.4 billion in 2012, and sales at
the Cerner Corporation increased by 60% over that same period. Today, 96% of hospitals have adopted EHRs, up from only 9% in 2008; the once-small EHR industry is now worth $13 billion a year.

The HiTech Act was implemented in stages: First, physicians and hospitals were rewarded with additional Medicare payments in exchange for purchasing and exhibiting “meaningful use” of EHR systems from approved suppliers. Beginning in 2015, physicians who did not adopt these systems were financially penalized for it. Despite this, half of physicians chose to accept reductions in their Medicare payments rather than implement what many consider to be a cumbersome, time-wasting, and even dangerous tool — particularly since, as the law is phased in over time, the requirements for fulfilling the definition of “meaningful use” will become increasingly demanding.

To date, the federal government has poured around $36 billion into financial incentives for hospitals and other health groups to adopt EHR systems, yet they are cited by physicians across the country as a leading source of anxiety. A strong plurality (nearly 40%) of physicians selected EHRs as one of two factors they find least satisfying about medicine, and over 65% reported that EHRs have detracted from their relationships with patients.

Doctors who have adopted these systems spend less and less time on face-to-face medicine and more time logging notes. A 2017 Health Affairs study found that, between 2011 and 2014, primary-care physicians actually spent more time on “desktop medicine” than with their patients. According to a separate 2018 study from the Physicians Foundation, 23% of physicians’ time is spent on non-clinical paperwork.

To mitigate this problem, many physicians have opted to hire “medical scribes” to literally follow them around taking notes for them. While some have praised this option as an effective means of lightening doctors’ note-keeping loads, others criticize the burgeoning industry as archaic and unnecessary. Still others argue that the purpose of a diagnosis should be to further the interests of an individual patient, not to bolster an IT system. In an attempt to cover every single possible medical outcome, many diagnostic codes are absurdly precise: The ICD-10 coding system, for example, was approved in 2014 and includes among its tens of thousands of individual diagnoses “sucked into jet engine, initial encounter,” “bitten by orca, initial encounter,” injuries while “knitting and crocheting,” and “problems…with in-laws.”
The pressure on doctors to use these systems is not a mere annoyance. According to a bombshell investigation conducted by Fortune magazine and Kaiser Health News, thousands of patient deaths, serious injuries, and near misses are tied to flaws in government-approved EHR systems. These risks are mostly hidden from the public due to secrecy policies such as gag clauses that prevent EHR buyers “from speaking out about safety issues and disastrous software installations.” The report, which was released in March 2019, is horrifying in its detailed descriptions of seemingly unnecessary deaths, amputations, and other medical catastrophes caused by sluggish or simply faulty computer systems. EHR vendors have paid hundreds of millions of dollars in quiet settlements over the years; few cases have made the news.

Perhaps what is most surprising is the candid regret expressed by both President Obama and former vice president Biden. As the Fortune report put it, “At a 2017 meeting with health-care leaders in Washington, [Biden] railed against the infuriating challenge of getting his son Beau’s medical records from one hospital to another.” According to Biden, “I was stunned when my son for a year was battling Stage 4 glioblastoma. I couldn’t get his records. I’m the Vice President of the United States of America… It was an absolute nightmare. It was ridiculous, absolutely ridiculous.”

In a January 2017 interview with Vox, Obama took a similar tack: “The fact that there are still just mountains of paperwork…and the doctors still have to input stuff, and the nurses are spending all their time on all this administrative work—we put a big slug of money into trying to encourage everybody to digitalize, to catch up with the rest of the world here. And it’s proven to be harder than we expected.”

David Blumenthal, one of the architects of the EHR initiative under the Obama administration, admitted to Fortune and Kaiser that EHRs “have not fulfilled their potential. I think few would argue they have.”

Part of the problem, according to the report, is the systems are so confusing “that errors frequently fall into a nether zone of responsibility. It can be hard to tell where human error begins and the technological shortcomings end.” Quantros, a health-care analytics firm, reportedly logged 18,000 EHR-related safety events from 2007 to 2018. A 2016 study by the Leapfrog Group, a patient-safety watchdog in Washington, found that hospital EHRs “failed to flag potentially harmful drug orders in 39% of cases in a test simulation. In 13% of those cases, the mistake could
have been fatal.” This drug-ordering feature is mandatory in order for an EHR system to be certified by the government.

Another issue is that doctors are over.warned by these systems. According to one study by the Oregon Health & Science University, the average clinician working in the intensive care unit may be exposed to up to 7,000 EHR-issued alarms per day—between 85% and 99% of which are false alarms. This excess of caution makes it extremely difficult for doctors to discern what truly warrants urgent attention, and medical emergencies have fallen through the cracks.

When MACRA was passed in 2015, it advanced what the HiTech Act had started by introducing two new systems, both meant to improve “quality and value” according to the government’s understanding of those terms. The first, the Merit-based Incentive Payment System (MIPS), was designed as a transitional program toward the second, the Advanced Alternative Payment Models (APMs). Under MIPS, which took effect in 2017, Medicare payments for physicians will be adjusted based on their scores in four categories: quality, resource use or cost, clinical practice improvement, and advancing care information.

Physician performance in each of these measures is translated into a composite score and posted to the new federal “Physician Compare” website, which was also created by MACRA. As more information becomes available in the coming years, consumers will be increasingly encouraged to look up doctors on this site to see what score they have been assigned by Medicare.

Unsurprisingly, each category contains an exhaustive and difficult definition. Quality scores, for example, are based on measures that doctors have very little control over, such as a certain average percent change in how quickly patients who have undergone spinal or knee surgery recover. Such measures largely depend on individual patients—the severity of their injuries, their age, and their compliance with physician advice—yet these quality benchmarks comprise 60% of a physician’s total score.

The “advancing care information” category further pressures doctors to adopt “meaningful use” of EHR systems; failure to do so will negatively affect their Physician Compare scores, and this category comprises 25% of the total score. Though the system is designed to be lenient at first, MIPS providers may see their Medicare payments reduced by as much as 9% by 2022 if they don’t comply with federal guidelines.
A Stat News report by Kip Sullivan and Stephen Soumerai called this technocratic approach a “dangerous... fad,” citing a major study that found “it actually penalized doctors for caring for the poorest and sickest patients because their ‘quality scores’ suffered.” Such crude performance measures do little to help patients or contain costs, they argued, despite their being “wildly popular among policymakers and the insurance industry.” Sullivan and Soumerai demonstrated that early endorsers of such scoring systems cited virtually no evidence that they actually work to reduce costs or improve outcomes. As a team of scholars in Medical Care Research and Review wrote, these programs “are being implemented in a near-scientific vacuum.”

Beyond the administrative and financial headaches EHR programs pose for doctors and the substantive physical risks for patients, a massive cyberattack in 2015 exposed the health data—including Social Security numbers, medical identification numbers, and birth dates—of 79 million people. In 2018, Anthem, Inc., one of the nation’s largest insurers and suppliers of EHR systems, agreed to pay $16 million to the Department of Health and Human Services to settle lawsuits related to potential privacy violations. This presented the largest known health-care data breach in U.S. history, and the largest sum ever collected by HHS in connection to a hacking incident, but it is far from the only successful attack on EHR systems. These programs are essentially mandated by law, but patients are placed at risk when they fail, and the HHS website contains a long list of reported data breaches.

RESTORING PHYSICIAN AUTONOMY

Data scares and bureaucratic messes aside, there is a more fundamental problem here. Applying the sort of “menu thinking” inherent to EHRs to the work of highly trained professionals seems more likely to increase risks than to contain them. Controlling and second-guessing doctors at every turn threatens to ossify the profession, rather than allowing physicians to develop professional judgment based on everyday, cumulative, patient-oriented experience. Psychiatrist Martin Lipp, in an early exploration of physician dissatisfaction, argued that doctors are “assaulted from within by the impossibility of knowing everything they feel they have to know, and from without by a system that removes authority and forces adherence to conflicting allegiances.”

72
The federal government, in pursuing innumerable objectives—attempting to control the budget, satisfy interest groups, and assure the public that it is trying to improve health care, to name a few—has come to look at doctors with a kind of domineering skepticism. Meanwhile, patient trust in doctors has declined, at least in part due to the changing look and feel of medicine following the EHR mandate.

In 1973, fewer than 15% of practicing physicians reported any doubts that they had made the right career choice. By 1995, 40% of doctors said they would not recommend the profession of medicine to a qualified college student, and around the same percentage said they would not choose to enter medicine if they were deciding on a career again. In 2018, over 62% reported feeling that doctors have “little” or “very little” ability to influence the health-care system.

But there are signs that officials in the Trump administration are taking notice of physicians’ objections. In July 2018, CMS administrator Seema Verma published an open letter to doctors in which she acknowledged some of the problems underlying physician burnout, including the “complicated and redundant processes” involved in complying with EHR systems, as well as “the inability to exchange records between systems—and the increasing requirements for information that must be documented—[that have] turned this tool into a serious distraction from patient care.”

Verma also discussed the administration’s “Patients over Paperwork” initiative, which is intended to streamline EHR documentation and redesign the incentive system in MIPS to “promot[e] the interoperability of electronic medical records.” This means it would provide financial rewards for doctors who comply with guidelines meant to make communication across EHR systems more efficient. In February 2019, Verma laid out a plan for a “digital data revolution” that includes improving the interoperability, or transferability, of health data. Participation in the interoperability program will significantly affect Physician Compare scores.

While this initiative seems well-intentioned, it is misguided. Rather than simply reshuffling incentives yet again, the federal government should recognize that the push to implement EHRs did not come from physicians or patients, nor does it meaningfully solve problems in the lives of either. Widespread availability of health data may be valuable, but only in a widespread sense—for health research, down the line. As one physician joked, he “didn’t go to medical school to become a
sharecropper for the EHR industry, growing and loading data for [them] to sell.” The data is extremely valuable, which is partly why different health providers and EHR vendors have been loath to share it, further complicating the risks to patient safety. Meanwhile, current patient care has been very clearly damaged by their implementation, and doctors ought not be penalized for choosing not to use them. In June 2019, CMS issued a request for public input on how to reduce administrative burdens for doctors and improve patient care. If the administration is serious about advocating for physicians and prioritizing patient well-being, it should simply remove the MIPS mandate on adopting meaningful use. Doctors who have already invested in these products may continue to use them, but those who haven’t should not be punished. Unlike the SGR, MACRA has been in place for less than five years, and repealing elements of the law will not overturn the industry.

The recently departed Food and Drug Administration commissioner, Dr. Scott Gottlieb, has also weighed in on EHRs, suggesting that government regulation of the systems may be helpful in coming years. But rather than layer on fixes of this sort, we should take a step back. The thousands of problems associated with EHRs are immediate and obvious. The problems they are intended to fix are vague. One proponent of EHRs compared this transition period to that of the shift from horses to automobiles—but there was no mass mandate to purchase cars. Physicians should not be required to use machines they don’t find useful.

Congress should also revoke or significantly revise the Physician Compare rating system, as it is not based on a definition of excellence that most doctors are trained to pursue or that patients would ordinarily seek. Unlike consumer-driven ratings sites, it provides top-down scores based on relatively arbitrary measures. It emphasizes compliance with bureaucratic demands based on business interests that are questionable at best, rather than on superior medical care. Following these requirements seems likely to further damage the already-strained dynamic between patients and doctors.

Another simple fix that would allow doctors greater leeway in the health market is lifting the price caps on physicians who do not participate in PAR. As of now, they are permitted to charge only 15% above Medicare-approved prices, even though they opted out of receiving the benefits offered to physicians who willingly signed on to Medicare’s pricing system.
Congress should also seek to reform the pricing system as a whole, removing the built-in rewards for family and rural doctors, which in essence amount to a special tax for other physicians. This is not to say that government initiatives supporting doctors in underserved areas are always a bad idea, simply that they have no place in Medicare, the goal of which is to provide insurance for seniors and disabled individuals. Presidents Kennedy and Johnson passed laws with specific grant programs funding doctors in areas where they wished to improve medical accessibility—a far more sensible approach. We can and perhaps should channel funding where there is a clear need, instead of punishing urban ophthalmologists via an enormous, national fee schedule they have virtually no control over.

Yet another way to bring doctors back into the conversation would be to lift onerous “antitrust” rules on the profession. A series of legal challenges against physicians, combined with “clarifying” regulations by the Federal Trade Commission and the Department of Justice, have placed doctors at a distinct disadvantage in negotiating prices with private insurers or the government. (Ironically, the Supreme Court case that had the largest impact in this area, Arizona v. Maricopa County Medical Society, concerned physicians who had agreed to keep their prices below a certain amount; they were not permitted to formalize this agreement.)

Insurance companies frequently merge and discuss prices with each other, the government, and other entities, but they have largely been shielded from meaningful anti-competitive action. And they are now powerful enough to intrude on clinical decisions made by doctors; for example, they can refuse to cover a certain treatment or medicine, and urge physicians to pursue an alternative that the doctor may not agree with. They frequently issue mandates tied to physician or hospital reimbursement, unilaterally revise contract terms, and seek to direct physician behavior through provisions on “medically necessary care,” yet doctors are virtually powerless to confer with one another regarding these policies.

Health-care executives have benefitted enormously from this structure, as market and regulatory pressures favor the information technology and quality measures that have been imposed on physicians at great cost. Meanwhile, physician incomes have stagnated or declined for decades. This is made worse by the fact that doctors are legally
responsible for all medical decisions they issue, which places them in an impossible position when guidelines are pressed upon them by some other entity. Insurance companies are virtually never held legally responsible for the medical decisions they pressure doctors to make.

There is a simple solution to this as well: Revisit the stringent rules preventing physician consolidation, and allow physicians to confer with one another regarding the prices and policies they negotiate with insurers. This would provide doctors with valuable information on the health-care market in general, relieving them from both being entirely in the dark regarding pricing and being entirely at the mercy of insurance companies or the government. It would also help to restore the place of doctors in conversations about what quality means in medicine.

Health care begins with the relationship between a doctor and a patient. Yet doctors have been eclipsed and, in some ways, crushed by insurers, EHR manufacturers, and the federal government. It is time to acknowledge their role in determining how to deliver medical care, and to return autonomy to the medical profession.