Testimony
Committee on Ways and Means

Re: hearing on physician organization efforts to promote high quality care and implications for Medicare physician payment reform:

July 24, 2012

by Jane M. Orient, M.D.
Executive Director, Association of American Physicians and Surgeons
1601 North Tucson Boulevard, Suite 9
Tucson, Arizona 85716
Telephone (800)635-1196; fax (520)326-3529; email address: aaps@aapsonline.org.
Thank you, Chairman Herger, Ranking Member Stark, and Members of the Subcommittee. It is a pleasure to have the opportunity to submit testimony on this important issue on behalf of the Association of American Physicians and Surgeons.

The Association of American Physicians and Surgeons is a nationwide nonprofit organization of physicians in all specialties, founded in 1943 to preserve and promote the practice of private medicine. AAPS represents thousands of physicians in all states and in all specialties and millions of American patients.

The objective of the Committee is to reduce Medicare costs while improving quality through reform of the physician payment system.

The basic problem is identified in an article I wrote for The Wall Street Journal on February 5, 1992, entitled “Health-Care Primer”: 

“Before we all drown in the details, it might help to recall the last time American politicians tried to solve a ‘crisis’ without confronting the core problem of price controls.” I referred here to the energy crisis of 1970 in which Jimmy Carter proposed tax credits, fuel subsidies, and a hundred other gimmicks to solve a problem whose roots were price controls on oil. “The result was mass confusion, and lines at the gas pump. Then Ronald Reagan removed the price controls, and the problem went away.”

Medicare price controls were instituted to try to control expenditures. These rose rapidly, not because of payment FOR service, but because of payment BY third parties.

The third-party insurer stands between the buyer and seller, disconnecting the normal free-market regulatory mechanism in which the buyer is spending his own money and the seller is competing for the buyer’s “vote” on the basis of both cost and quality, i.e. the value of the service.

Every Medicare transaction is governed by a rigid system of price controls called the Resource-Based Relative Value Scale. The scale is supposed to take into account the work, time, and effort associated with the service, with some variability permitted on the basis of regional variations in practice costs—but not for skill, training, or experience of the physician or other “provider.” It has nothing to do with what the practitioner is willing to accept or what the patient is willing to pay, with quality, or with mutual agreement about fairness.

As this system fails, Medicare proposes to impose an even more onerous and complex system of quality measures to “incentivize” quality.

The main incentive for physicians is the joy in making a diagnosis, skillfully performing a procedure, and helping their patients. Physicians have to be the most highly self-motivated group in America to survive medical school and rigorous years of post-graduate training.
Medicare “incentives” to perform bureaucratically prescribed tasks, which are generally regarded as irksome busywork, detract from the enjoyment of the real work. They cause demoralization rather than eagerness to work or to strive for improvement. No method has ever been described by Medicare that can make a physician more intelligent, more attentive, more compassionate, or less fallible.

It is certain, however, that non-payment for service, or payment for non-service will result in less work, not more efficient work.

How should quality be measured? There is no agreement on what exactly constitutes quality. The measures that are generally proposed are process variables, such as the percentage of patients who get a certain type of drug therapy, certain laboratory measurements, and anti-tobacco and obesity “counseling.” These concern physician compliance with bureaucratically established guidelines. The incentive to perform and document these factors is a slight increase in payment that probably does not even pay for the data collection hardware, software, and work. The disincentive or punishment is a decrease in pay. Many physicians respond by decreasing the number of Medicare patients they see.

“Outcomes” (patient health measurements) are generally surrogate variables, not longevity or morbid events. These are highly dependent on patients’ behavior and prior health status.

Most of the (dis)incentives in non-FFS based payment are punishments for providing “excessive” (more than average) service, or treatment that is outside the “guidelines.”

We suggest that the most important outcomes are not among those proposed, and may not even be measurable: 1. Timeliness of service; 2. correct diagnosis; 3. overall improvement in patient well-being.

It is assumed that all practitioners are alike, that every service with a given code is alike, and that all patients are alike. All of these assumptions are false.

An enormous problem that added administrative demands can only worsen is the looming shortage of physicians, both by driving physicians out of practice or diverting their energies away from patients. The exodus of more than 100,000 physicians is expected by 2020. One of these physicians is Dr. Constance Uribe, who wrote a column in the July 19th issue of The Washington Times. Dr. Uribe is a general surgeon who has taken care of about 80% of the breast cancer patients in the area surrounding Yuma, Arizona, on the California border. She states, “Since the 1980s, my career has been riddled with regulations created by a government bent on controlling every aspect of patients’ lives. The coup de grâce was delivered by the Affordable Care Act.”

Electronic health records are supposed to improve efficiency and quality. Dr. Uribe quotes another physician, who wrote on a blog, “It adds an hour of time to my day and makes my office notes sound like they were written by an imbecile.” Like many of her colleagues, Dr.
Uribe is not saddened by the prospect of retirement, as physicians were in earlier times, but is relieved that she will no longer have to deal with “uneducated bureaucrats and medical directors committed to pigeonholing people and withholding care.”

Medicare ought to be counting physicians, administrators, and the physician-to-administrator ratio. The number of physicians has increased 100% between 1970 and 2009, but the number of administrators has burgeoned by nearly 3,000%. Any method that worsens this trend should be rejected.

As the AMA points out in its publication entitled “Guidelines Reporting Physician Data,” physicians are unable to understand the data in various physician profiling programs that are supposed to influence their behavior. If physicians cannot even understand them, what good are they?

As the AMA recognizes, there is a minimal sample size of patients, opportunities, and episodes required for statistical validity. But what is not so often recognized is that attempts to compare individual practices run into insurmountable obstacles to statistical validity. First are the hazards of dealing with the small sample sizes. Even less commonly recognized is the fallacy of making multiple comparisons. If one subdivides a population according to all of the important variables, or even a small number of them, one rapidly has tiny sample sizes in each category and huge numbers of comparisons being made. It ensures that no statistically valid conclusions can be drawn.

An additional enormous problem is that although there are extremely complex formulas for calculating what “reimbursements” should be, it is virtually impossible in many instances to determine either what a service cost or what was paid for it, especially in hospitals. Thus, patients cannot make cost comparisons.

The most important change in payment methodology is direct payment by the person receiving a service, who is then reimbursed by the insurer if appropriate. All costs should be transparent. The value of quality measurements should also be assessed by patients’ willingness to pay for them. It is quite likely that patients will not be willing to pay for expensive machinery to make meaningless quality measurements.

Value is ultimately determined by the person receiving the service. Where is the evidence that CMS-proposed measures are any better than patient assessment or the opinion of the physicians’ colleagues, coworkers, or other patients?

Costs will never be controlled without eliminating the corruption and perverse incentives inherent in any system in which a third party is paying the bills.

There is no incentive better than competition in a free market: that is, voluntary transactions, honest pricing, and low barriers to market entry.
Congress should reject gimmicks to compensate for problems caused by previous government interventions, and instead remove the cause of the problems—interference with the free market.

Respectfully submitted,

Jane M. Orient, M.D.