PHYSICIANS: WILL GETTING RID OF THE ACA CURE WHAT AILS YOU?

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In this article…

Some of the most persistent physician complaints won't go away if the Affordable Care Act is repealed.

AS I ADDRESSED IN MY PREVIOUS INSTALLMENT, there are two significant challenges to the Affordable Care Act (ACA) in 2015: congressional repeal and the Supreme Court's decision in *King v. Burwell*. Republican lawmakers continue to call for a full repeal of the ACA, though these calls have abated somewhat since the heady days of January when the GOP first took leadership of the Hill. Recognizing the certainty of a veto by President Obama if Congress should act, the real threat to the ACA lies with the court, where an adverse decision in *King v. Burwell* will eviscerate the ACA.

There are certainly some physicians who are energized as they imagine the end to the ACA and relief from the tribulations in medical practice that many attribute to the law. The reality, however, is that these frustrations — certainly the top five — are not based in the ACA so there is widespread misunderstanding of what the law actually mandates and controls. None of these irritations will disappear — even if the ACA does.

Physician leaders working to build alignment and integration among their peers — who are working to facilitate the transition of medicine from a cottage industry to population health — are already experiencing how difficult that process can be. The grievances prevalent among typical doctors feed their resistance to change, as do false hopes that any of them might disappear. Misunderstanding about the origins of these complaints are contributing to the challenges of leadership.

PHYSICIAN COMPLAINTS: WHAT ARE THEY? — An informal, anecdotal survey of physicians I have encountered over the year leading seminars across the country has demonstrated remarkable consistency as to what are perceived as the top problems with the practice of medicine, with little variation due to region or the particular specialty of any one doctor. Although the order varied, physicians predictably listed five issues as their biggest complaints.

1. **The increasing use of electronic health records (EHRs), which require increased time to document care — especially given the number of requirements in place to be eligible for meaningful use incentives.**

   As one surveyed physician told me, EHRs "are seen as barriers to patient care, practice efficiency and expressing thoughts well."

   Complaints about EHRs are fairly uniform and understandable as the transition has been cumbersome, lengthy and costly on the level of an individual office and the nation at large. Digital medical records contain important information that must be immediately available across EHR platforms, must protect the security of the information from malicious use as well as inadvertent privacy breaches, can be voluminous and difficult to digitize (given a wide variation in handwriting and legibility), and must accommodate multiple users who are accessing the records for reasons as diverse

as billing audits to crisis intervention in a life-or-death emergency.

All of this is being put into the hands of physicians who did not (for the most part) volunteer for the transition, who have very specific practice patterns (such as the order of physical exam findings), and who were trained long before computers were commonplace.

They may be great physicians, but they are keyboard illiterate. In sum, it is not as easy to digitize a medical practice as it is to upgrade a convenience store, especially when the store can pass on the cost to its consumers and the physician cannot.

Will all of this go away if the ACA dies?

No. The paperless health care system — with all its anticipated benefits for the accuracy of health care delivery and evolution of population health — came about in the early 1990s (and even earlier when discussed theoretically).

A multitude of federal and state laws govern privacy concerns and security rules, including — most significantly — all the various rules falling from the Health Insurance Portability and Accountability Act (HIPAA), and the inability to pass on the expense of digitizing a practice is a core component of Centers for Medicare & Medicaid Services' (CMS) regulations, fraud and abuse laws and private/payer contracts. Most to the point, "meaningful use" stems from the American Reinvestment and Recovery Act of 2009, and it is not part of the ACA.

The ACA may endorse EHRs in multiple ways, but it certainly did not invent them.

The impact on this issue in a non-ACA America? **Nothing changes.**

2. **Decreasing reimbursements and reimbursement reform have resulted in many physicians taking care of a greater number of patients just to recoup lost income.**

And the complaint is that this results in more stress, decreased attention to individual patients, less professional satisfaction and loss of the physician/patient relationship.

But the decline of reimbursements for physicians has been a reality for decades. The evolution of managed care in the `80s and `90s brought private contracts under which physicians accepted lower reimbursements and modified fee-for-service payments. Similarly, Medicare has been reducing rates consistently for decades. Anecdotally, one ophthalmologist admitted to me a two-thirds reduction in income (inflation aside) since the 1980s. So, whether by private contract (as pressured by the prevalence of managed care in this country) or reduced rates (subject to CMS), we cannot deny that physicians are making less and may be compensating with higher patient loads.

Will this go away with the potential loss of the ACA?

Certainly not, particularly as it pertains to private insurance contracts, which are not subject to the law.

The impact on this issue in a non-ACA America? **Nothing changes.**

3. **Increasing costs and demands for compliance in every practice setting mean that even solo physicians must have staff devoted to complying with many laws and regulations.**

This includes billing, patient privacy under HIPAA and state laws, employer responsibilities such as those from the Occupational Safety and Health Administration, assuring best IT practices and sufficient documentation to appropriately receive meaningful use funds, addressing patient complaints and satisfaction (especially as these will now be tied to reimbursement), preventing errors or perceived errors and negligence claims, as well as addressing requirements pertaining to equipment upkeep, samples, laboratory equipment, and on and on and on.

As daunting as that list of compliance concerns is, it does not include all the other expenses associated with medicine, such as licensure and insurance. The cumulative effect of all these outlays makes the overhead just too big for a small office to absorb.

The expense of running a medical practice — especially a solo or small office where there are no efficiencies of scale — is frequently identified as the number-one reason physicians are closing their offices to become employed at large hospitals or health care systems — or else retiring all together.

Many physicians who have made that choice regret the loss of their own practice, while their colleagues remaining in a traditional setting mark their attrition and bemoan the loss of entrepreneurship and independence in medicine.

Of course, all these compliance requirements come from multiple laws passed on both the state and federal levels over the past two to three decades, not because of the ACA. Will the cost of running a practice diminish with the demise of the ACA? No.

The impact on this issue in a non-ACA America? **Nothing changes.**

4. **Quality measurement and value-based purchasing cause concern among many physicians, especially as several (in the words of a colleague of mine) "are not convinced that actual value is being measured by the current metrics."**

The importance placed on objective measurements such as laboratory values — like a diabetic's hemoglobin A1C — is frustrating when it does not assess the recalcitrance of the underlying disease, the importance of progress made even if the laboratory report is still too high, and especially when the metric does not allow for recognition of the role of patient compliance in fighting their own disease.

This leaves some physicians resisting quality initiatives — not because they are against quality — but because they feel they are being measured in an unfair, "top-down" administrative manner that does not recognize the realities of treatment on the level of an individual patient.

This complaint is closer to the ACA than the first three because "value-based purchasing" is, in fact, contained in the ACA, but it did not start there. The concept of reimbursement based on quality ("pay for performance") indicators has been prevalent in multiple industries for years, and there were certainly renowned health care systems that intertwined quality and reimbursement before any national movement.

The primary force pushing American medicine toward a pay-for-performance model was the 2001 Institute of Medicine Report titled *Crossing the Quality Chasm* — the pilot project testing those ideals in California led to Congress' adoption of pay for performance for CMS in December 2006.

So although what we know today as value-based purchasing is recognized and included in the ACA, it neither started nor would it die with the ACA. This is particularly true for private insurance companies that have demonstrated a significant commitment to reimbursement reform, bundled payments and quality-based reimbursement, for again they all operate through private contracts and are not subject to CMS rules.

The impact on this issue in a non-ACA America? **Nothing changes.**

5. The loss of physician control is a perception voiced by many doctors and is the flip side of the evolution of a team approach to patient care, and the increasing importance of comparative medicine and established, standardized treatment pathways.

The medical home best personifies the team approach to medicine — and for all the potential for coordination and patient-centered care they may emulate, the medical home is a far cry from the trusted personal physicians on the corner remembered fondly by so many.

As the health care field is flooded with advanced practice registered nurses (APRNs) and physician assistants (PAs) — as the term "physicians" is now replaced with "providers" or "prescribers" — there is a fading memory of medicine as it was practiced in the not-too-distant past. The need for more people to offer health care to a ballooning population does not negate the power of nostalgia for a world that is changing.

At the same time, comparative effectiveness does not represent a change in medicine as much as it exemplifies the enormous speed and distribution made possible by the paperless health care system so many physicians are having trouble adjusting to.

Medicine is a science, and the need for continuing medical education has been core to physicians since Hippocrates — but now the ability to transmit scientific results rapidly results in an expectation that physicians will change their practice patterns on a dime, and with uniformity.

The standardization that is the goal for so much of health care policy occurs to many physicians as the loss of independent medical decision-making. Long derided as "cookbook medicine" there are still physicians in the field that resist being told how to care for their patients.

One does not have to agree with any of this resistance to sympathize with how difficult change can be, but these are all trends that extend long before the ACA.

The impact on this issue in a non-ACA America? **Nothing changes.**

CONCLUSION — The ACA has proven to be one of the most controversial, yet also misunderstood, laws in recent history, which can be attributed to inaccurate press reports, political agendas, confusing language within the law itself and failure on the part of the Obama administration to explain the ACA to the public (including physicians) sufficiently.

Not surprisingly, the law has become the scapegoat for many changes in health care, and many physicians lay their biggest complaints at the feet of the ACA, with unrealistic expectations that repealing the law — or judicially killing it — could cure their woes. The disappointment and anger that will inevitably follow the demise of the ACA — should that occur — may only serve to increase the challenges of physician leadership. ■

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