Obamacare Report Card

Analysts and the nation's physicians weigh in on how the Affordable Care Act has affected the daily practice of medicine

by Joanna Haugen and Jordan Rosenfeld contributing authors

The Affordable Care Act (ACA) has been a lightning rod for criticism from various healthcare stakeholders, including physicians, since the law's passage six years ago.

With the upcoming presidential election likely to alter the landscape of "Obamacare"—from simple tweaks by Democrats to outright attempted repeal by Republicans—Medical Economics asked healthcare policy experts and our readers to debate the law's effect on U.S. physicians.

Our editorial staff, with the assistance of our physician advisers, selected eight provisions and consequences (both intentional and unintentional) stemming from the law. Policy analysts provided their thoughts on how Obamacare has shaped the last six years. Then we asked physicians from our editorial advisory board, our 200-member Reader Reactor Panel (comprised of physician readers nationwide who help direct our content), and our e-newsletter subscribers to grade the various elements based on their own experiences. Each physician ranked each element in terms of how it assisted their day-to-day work as physicians on a score from 0 (not at all) to 10 (extremely helpful). The average of all respondents was used to derive the letter grade. Physicians also offered short justifications for their ranking.

Medicare bonus for primary care services

GRADE: 33 = F

In July 2011, the Centers for Medicare & Medicaid Services (CMS) implemented the Primary Care Incentive Program (PCIP), a provision of the ACA designed to address disparities in Medicare reimbursements between primary care providers and specialists. This was driven by concerns from a Medicare Payment Advisory Commission's (MPAC) annual report that primary care physicians' fees were being undervalued compared to specialists who provide discrete procedurally-based services. Enrolled physicians could claim a 10% bonus fee for services paid for under the Physician Fee Schedule (PFS) for any Medicare patient in their care, new or existing.

The program paid out $664 million in 2012 to approximately 170,000 primary care physicians, an average of $3,938 per provider, according to the MPAC report.

Analysis

This program was necessitated by the growing numbers of primary care physicians who were closing their practices to Medicare patients, due to the many challenges of meeting Medicare rules and regulations, according to Mark Rust, JD, managing partner of Barnes & Thornburg LLP, and past chair of his firm's National Healthcare

Department in Chicago, Illinois.

Physicians were "dropping the program if they could get away with it, and if they couldn't, [making] shorter visits to try and keep their heads above water with the level of payments they were getting and concomitant administrative demands made by Medicare," he says.

There's also a subtle professional rivalry between specialists and primary care physicians, says Anthony Lo Sasso, PhD, professor of health policy and administration at the University of Illinois, Chicago. "Specialists doing the invasive, more costly, higher-reimbursement treatments would say these are very skill-based [services], but primary care says, 'well, we're trying to change their behavior, prevent them from having angioplasty or what have you, so maybe that's more valuable.'"

Primary care is underfunded, agrees Tim Hoff, PhD, professor of health management and health policy at Northeastern University's McKim School of Business in Boston, Massachusetts. However, he feels that giving money for just two years and then taking it away is not a long-term solution. "The reimbursement [for physicians] is not where it needs to be, and very often the solutions are these very temporary quick fixes. Let's give everybody more money but then when the money gets taken away, it puts the primary care physicians right back in the same position they were in before."

Analysts are not convinced that the temporary increase in reimbursements helped PCPs sufficiently to call the provision a success. "You can certainly appreciate the extra 10% that you get for those services," Lo Sasso says, "but I think if it was a permanent change, then that would change the calculus."

Rust is more conclusive. "It failed to create a sustained atmosphere for raising the level and quality of service in the action of providers," he says.

Whether physicians really benefited from the bonus also depended on the size of the practice. Hoff says one quarter of primary care physicians didn't earn any incentives because their practices were simply too full to take on new Medicare patients.

Practices that did benefit from funds to expand services or administrative staff were then left in a financial lurch once the program concluded in 2015. This is likely to have trickled down to patient care, says Hoff, "if you are a patient that benefited from some of these investments that some practices made with this Medicare money, and then those go away."

Ultimately, unless Congress passes legislation to refresh or revise the incentive program, Rust feels that it can be best considered "a one-time drop in the bucket. This is the typical approach of the federal government: throw a little bit of money at something and say we solved the problem," he says.

MPAC recommends replacing the incentive model with a per-beneficiary payment model, which would encourage high-quality care through the use of care coordination teams, rather than the fee-for-service approach, which rewards high volume of services over quality of care.

Physician Feedback

"One time is not enough. It's like saying your veteran's medical benefits for the leg you lost should only be for one or two years when it affects you and negatively impact the rest of your life."

"The ACA has slowed down my work flow far more than what provided me to compensate."

"It was a silly Band-Aid"

"This is such a minuscule amount of money compared to what it takes to run a medical practice. It is totally meaningless."

"The extra money was helpful, but it still did not bring us into parity with specialists."

Medicaid-Medicare parity

GRADE: 34 = F

The ACA required individual states in 2013 and 2014 to reimburse qualified providers—family physicians, internists, and pediatricians—under Medicaid at the same rate they were paid for services under Medicare. The federal government paid 100% of the difference, which amounted to approximately $5.8 billion in 2013 and $6.1 billion in 2014.

This provision, often referred to as "Medicaid primary care parity," was designed to encourage PCPs to participate in Medicaid. It was included in the ACA because physicians have been less willing to treat Medicaid patients than those covered by Medicare, most often due to lower reimbursement rates.

In a study by the Center for Healthcare Strategies, just 66% of physicians accepted Medicaid patients versus 82% that accepted Medicare patients. Also, given that the ACA was designed to significantly increase enrollment in Medicaid, the incentive program hoped to close this gap.

Despite hopes that federal lawmakers would reauthorize the reimbursement increase in 2013, they did not, so the program ended in December 2014. States were left with the option of deciding whether to revert to the previous payment levels or continuing at the higher levels without the matching federal funds. As of March, 31 states and the District of Columbia had decided to continue paying the enhanced rates, while 19 states had declined.

Analysis

Determining whether it worked is tricky. Analysts feel that its short duration and lack of effective data on what motivates practitioners to accept Medicaid patients poses challenges to measuring the program's efficacy.

"The federal government oftentimes acts like they can wave their magic wand, and create great social policy with an idea they unilaterally came up with," Rust says. "If the states are rejecting it, there's a reason why: it's not working." This could simply mean that states don't want to spend the money.

The difference in rates between Medicare and Medicaid payments also varies from state to state, says Lo Sasso. However, he cites a 2012 University of Pennsylvania study that showed "the magnitude of the fee increase was associated with an average greater appointment availability. "So that would suggest that physicians' practices did respond to some degree," Lo Sasso says.

It's difficult to determine if already over-burdened primary care physicians are motivated by higher reimbursements to take on more Medicaid patients. "I don't think that most physicians consider the compensation pay for Medicaid patients to be worth the effort of putting the claims in. So the willingness to treat Medicaid patients, in my experience, has usually been out of a sense of charity," says Lo Sasso.

Though physicians' motivation for taking on Medicaid patients vary, many are facing increased patient loads and administrative burdens that affect their ability to take on new patients. "You can provide these bumps in funding and reimbursement but it's a capacity issue at this point," Hoff says. "Is it significant enough to really enable these practices, particularly smaller ones, to increase their capacity? Not really."

Although the program was not as effective as some would have hoped, the healthcare community shouldn't be so quick to write off the program as a failure, says Carrie Nixon, JD, co-founder and CEO of Healthcare Solutions Connection and managing member of the Nixon

Law Group in Fairfax, Virginia. She feels that healthcare reform has and continues to be "a grand experiment" at innovation and reform. "Generally we don't get things right the first time around," she says.

However, Nixon is concerned about the implications for Medicaid patients, who are low-income, and include a large number of elderly and patients with mental illnesses. If PCPs aren't incentivized to take more Medicaid patients, she says, "We'll have more people visiting emergency rooms and driving up costs. That's not a sustainable solution."

The solution to the problem ultimately lies in further legislation, but any real progress is unlikely before this year's presidential election.

Physician Feedback

"I'm grateful for the parity, but it was too short-lived."

"Once again a short-term fix for long-term problems which mandates one and then walks away to leave someone else holding the bag."

"Temporary increases do little to change the trajectory of the demise of primary care."

"My work load has gone up tenfold with all the forms and paper work. I can't keep up any longer with regular patient care."

"I wasn't fooled into taking short-term money for long-term pain."

"It hasn't improved my daily work. But it has improved access for patients which I really do appreciate. It has allowed us to offer our services to a group that otherwise we would not be able to afford to do so."

Increased coverage through healthcare insurance exchanges

GRADE: 35 = F

One of the key goals of the ACA was to increase access to affordable health insurance by providing options for uninsured Americans with pre-existing conditions, extending coverage for young adults and expanding coverage for early retirees. For people ineligible for Medicare and Medicaid, this coverage was made available through online marketplaces, or exchanges.

Initial estimates from the Congressional Budget Office in 2012 were that between 23 million and 25 million people would receive coverage through the exchanges from 2016 on, but actual enrollment has been lower.

During the open enrollment period for 2016, about 12.7 million consumers signed up for coverage through the exchanges—9.6 million through the federally-run HealthCare.gov website and 3.1 million through state-based marketplaces, according to CMS. Though current enrollment numbers have not met the estimate noted in 2012, this is a significant number and should be considered a success, says Hector De La Torre, executive director for the Transamerica Center for Health Studies in Los Angeles, California.

Analysis

The ability of consumers to clearly see and compare insurance policies when purchasing has been lauded as a success of the exchanges. "Greater choice and greater transparency has allowed some individuals to make more informed buying decisions," Hoff says, noting there are more product varieties tailored to different needs and abilities to pay and access particular types of providers.

Despite the apparent success of the exchanges, however, they have experienced problems. The launch of the federal exchange was marred by computer problems that undermined early enrollment, and some states completely botched the rollout of their exchanges. Oregon, for example, failed to launch an online enrollment portal for its Cover Oregon exchange in a timely manner.

Though coverage is now more available because of the exchanges, affordability remains a problem for some. Premiums on the exchanges increased more in 2016 than in 2015, with policies for the lowest and second-lowest cost silver plans running on average 4.4% higher, according to the Kaiser Family Foundation. Due to these higher rates, many people are opting for plans with high deductibles and high copays in order to avoid paying higher monthly premiums.

"There is a tradeoff," De La Torre says. "People are looking for the cheapest plans and prices, and they're limited in what they get for that, and it means more out-of-pocket expenses." Additionally, many of those who have bought coverage through the exchanges had a greater need for medical care, but this hasn't been counterbalanced with healthy enrollees, some of whom have chosen instead to pay a penalty for going without healthcare insurance.

"Basically what the exchanges attracted was 100% of the sick people and a smaller percent of the healthy people," Rust says. To address this imbalance, the ACA authorized risk corridors to help stabilize costs for insurers by offsetting high losses and sharing in large profits, but these will end at the end of 2016.

This preference for lower premiums, the disproportionate percentage of unhealthy participants and the looming end of the risk corridor program have had a cumulative effect, and insurance companies have felt the pinch. For companies like UnitedHealth, Aetna and Humana, participating in the state exchanges provided an opportunity to remain competitive with rival companies, but it's come at a cost. "They're trying to balance the need to compete effectively with other insurers by price or premium while at the same time comply with the mandate of the law that covers a pretty robust basket of services," Lo Sasso says.

In April, UnitedHealth, the largest health insurer in the country, announced that it plans to drop coverage in most state exchanges by 2017, citing small markets and substantial risks that resulted in a $475 million loss on ACA exchange policies in 2015 and a projected $500 million loss this year. While 145,000 people currently enrolled with UnitedHealth will need to change insurance providers, they represent a small percentage of Americans insured through the exchanges.

For its part, the government appears unconcerned: "As with any new market, we expect changes and adjustments in the early years with issuers both entering and exiting states," said Benjamin Wakana, a spokesperson for the U.S. Department of Health and Human Services (HHS) in an emailed response to the announcement.

Physician Feedback

"High deductibles and copays essentially render patients with these insurances 'insuranceless,' except for prevention visits. If anything is found the patient is unable to afford subsequent care and do does not seek it. No real gain."

"Coverage is shockingly bad, and at a high price."

"Getting people on insurance has been helpful but

clumsy. High deductibles appears to me to be a by-product of insurance companies protecting their assets."

"Why would selling an insurance policy with a large deductible help someone who can't even afford the premiums? They can't pay the deductible, so they still can't afford care. Who made out? Insurance companies. Who lost? Private practice doctors who had to deal with patients who stiffed them for the deductibles on policies. Thanks Obama!"

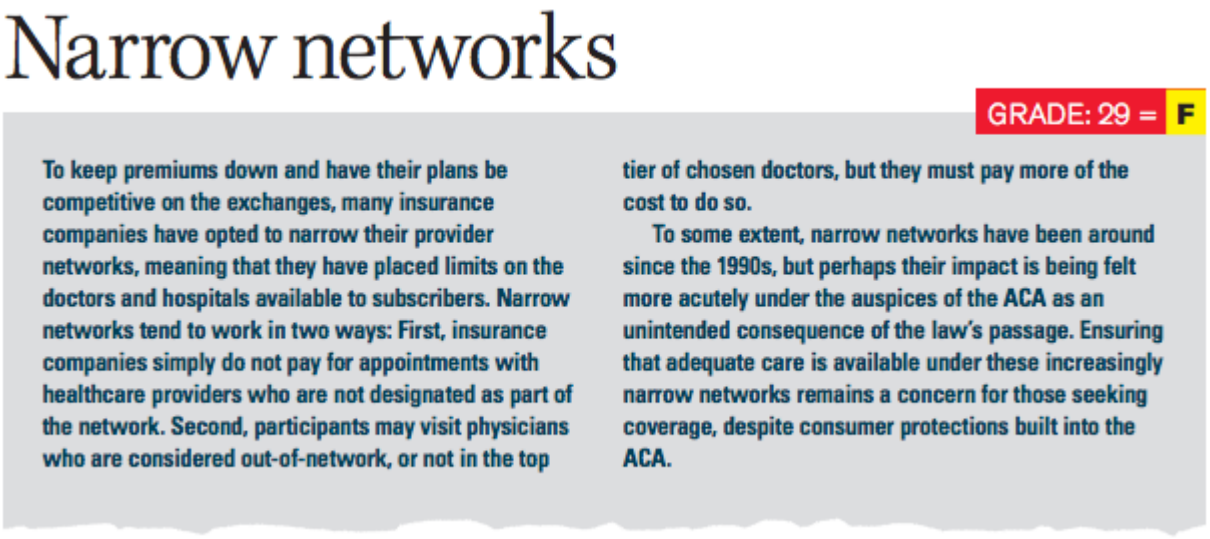
"Many patients have been able to access health care that they were not able to access previously."

"[Physicians] have been the ones who have to explain that the patient does have to pay their exorbitant copays—usually we end up with zero and an angry patient."

"We are getting patients in with many problems and don't always have the resources to address them."

"Things are worse trying to determine benefits and coverage."

"More coverage is good, but more coverage does not equal more access."



Analysis

When employers are deciding what insurance plans to offer their employees, Rust says, they often choose plans with larger networks because they have to please a large number of employees. However, when individuals are choosing their own plans, they're more likely to consider the balance between coverage options and cost, and "it becomes much easier to offer a narrow network at a less expensive price and let the consumer decide," he says.

According to the consulting firm PricewaterhouseCoopers, many exchange plans have narrower provider networks with more limited options for healthcare providers and facilities than employer-provided plans, but employer interest in narrow networks is increasing as well. Limited networks include PPOs (preferred provider organizations) and health maintenance organizations (HMOs), both of which can be effective in reducing premium costs. PPOs limit networks to providers willing to accept reduced rates set by the plan, while HMOs use a dedicated

provider network to manage care and reduce costs.

In fact, consulting firm McKinsey & Co. found that about 70% of plans sold on exchanges had limited networks. Additionally, a University of Pennsylvania study found that in 16 states, 50% or more of the health plans sold on ACA exchanges had narrow physician networks. "It's allowed, it's what their competitors are doing and it's what consumers are asking for in terms of price," De La Torre says.

Price is a huge determinant when consumers choose a healthcare plan on an exchange, and some analysts have questioned whether they give up quality in the process. A report by AcademyHealth notes that, in general, quality is not a criterion for exclusion or inclusion in a network, and participants struggle with measuring the relative cost, efficiency and quality of healthcare providers.

"It is possible that you could get a narrow network…with very poor quality physicians and hospitals," Rust says. "It's not, in my experience, extremely likely, but it is possible."

Limited consumer choice may only become apparent once specialty care is needed or provider options are severely limited. "It's already creating bigger access problems across the country," Hoff says, noting that it may take several months to see a specialist if only a few are available through an insurance plan.

De La Torre agrees: "Certainly in rural areas, people may be forced to travel long distances to see a physician or go to a facility that is in-network," he says. Or someone who develops a condition that requires specialists may find minimal options to meet those needs within the network. Additionally, lists of providers included in a network are often outdated, making it difficult for patients to determine whether their preferred physicians are included.

The ACA requires that all "qualified health plans" include an "adequate" selection of primary care providers, specialists and other ancillary healthcare providers, but a recent study published in the Journal of the American Medical Association found as many as 14% of plans sold on the federal government's health exchange were "specialist-deficient" (with endocrinology, rheumatology and psychiatry being the most commonly excluded specialties). Ultimately, this can result in a hefty out-of-network financial burden.

These networks have benefited some physicians because they have received enhanced reimbursements and a guaranteed flow of patients from being in-network. However, "some of them are going to be overwhelmed," Hoff says. If there is a high demand for specific providers within a plan, those physicians are under pressure to meet the demands of their patients even if they cannot serve them in a timely manner, he says.

As narrow networks have blossomed under the ACA, questions are being raised as to who, if anyone, should oversee this trend, since few regulations exist. "There are regulations out there on network formation that address narrow networks from the federal government, but it is really much more something that state regulators know and understand," Rust says. In addition, he notes, there is tension between regulations that kill narrow networks and healthy competition that drives down prices.

Physician Feedback

"Patients often do not understand the implications of a narrow network. I end up having to take time to explain the plan—something the insurance company should do or reimburse me for my time doing their job."

"There are far too many restrictions placed on physicians in allowing them to participate in plans. Unnecessary!"

"Insurance companies are prohibited from cherry picking health patients, so they cherry pick physicians who treat healthy patients."

"Patients are squeezed by ever pared down numbers of physicians on these lists. If I can't send my patients to specialists within a reasonable travel time, the patient simply can't go. This is particularly true in rural areas."

"It is unfair and profits a few. If a physician has a license in good standing they should not be eliminated from an insurance plan."

"[Obama said] 'If you like your plan, you can keep your plan.' The result? Reduced choice."

"The network delineations in our area are so arbitrary and inappropriate that all they do is impede care."

Analysis

Participation in an ACO is voluntary, but some physicians have felt pressured to join one so as not to miss out on potential referrals, especially if nearby hospitals or other providers have joined one, says Gary Young, JD, PhD, director of the Northeastern University Center for Health Policy and Healthcare Research in Boston, Massachusetts. Despite the lure of ACOs' intended benefits, many participants have felt the initiative's growing pains.

When it launched, 27 ACOs were selected to participate in the MSSP, and by January 1, 2016, there were 434 participating ACOs across the country serving more than 7.7 million beneficiaries. The Pioneer ACO Model, an initiative by CMS to test alternative ACO program designs to inform the evolution of the MSSP, launched in January 2012 to support organizations that already had experience operating an ACO.

"They were selected because they'd already made progress in building the fundamental infrastructure and capabilities that were required to coordinate care, reduce costs and manage risks," says Rita Numerof, PhD, a healthcare business strategist and president of Numerof & Associates in St. Louis, Missouri. "If anyone could be successful in providing accountable care, these would be the ones that would be able to do it."

However, only nine Pioneer participants remain after others dropped out of the program. According to an August 2015 CMS report, among ACOs that entered the program in 2014, 19% generated shared savings, compared with 27% of those that entered in 2013 and 37% that entered in 2012. "There are a surprisingly large number of people who formed ACOs and entered this market who have since dropped out and/or reported they were unable to achieve anything that got them to bonus payment levels," Rust says.

Nixon is optimistic about the future of ACOs: “Now we’re working to fix the parts that need to be fixed and tweak the parts that need to be tweaked. We saw in the new Medicare Shared Savings Program final rule that came out last year that CMS was actually listening pretty well to the participants in the program,” she says.

Building on previous models, CMS launched the Next Generation ACO Model in January 2016. Like its predecessors, the 21 initially participating ACOs can take on greater financial risk with the opportunity to share in more of the financial reward. However, this model has a prospectively-set benchmark for success and includes more incentives for beneficiaries who seek care from a Next Generation provider.

Though the road to ACO success has not been easy for participating providers, it has reportedly saved the government money. According to a January 2016 HHS analysis, there was a combined net program savings of $411 million for 333 MSSP ACOs and 20 Pioneer ACOs in 2014.

Young points out, however, that there isn’t much detail as to exactly where those cost savings are occurring. For example, are physicians actually getting rid of superfluous testing, or are they referring patients to less-expensive specialists? “I don’t think we fully have a good grasp yet of what is driving some of the savings we may be seeing,” he says.

Physician Feedback

“ACOs are a lot of work: some of it beneficial across all products, and other parts are so much busy work.”

“So far this creates the best opportunity for better care and lower cost.”

“ACOs and layers of work for physicians, reducing our ability to spend time with our patients and adding unnecessary burdens to our already busy schedules. And all of this with marginal if not negligible benefit.”

“As a primary-care provider, I'm totally neutral. It rewards us for doing the right things (coordinating care, for example), though it does not give us the resources up front to do so.”

“This is managed care reintroduced under another name. There will be temporary savings then rapidly increasing costs again as the market becomes controlled.”

“Patients fear the ACO practices are withholding care due to costs. There has also been animosity among 'team members' over who should get how much money if there's savings.”

Outcomes-based reimbursement

GRADE: 28 = F

Historically, payers have used a fee-for-service (FFS) model that paid physicians for every service and test they provided based on customary charges of similar physicians in a geographic area. As a result, many physicians felt a sense of urgency to see as many patients as possible as quickly as possible—a potential detriment to patient care and source of physician burnout.

The ACA implemented several new programs intended to improve the quality of care, but the Medicare Access and CHIP Reauthorization Act (MACRA) significantly modifies the FFS model. This shift in physician reimbursement is designed to promote value over volume, because physicians are rewarded when they report data and outcomes that show they have achieved appropriate value-based outcomes.

Analysis

After spending years focused on how many patient appointments they could squeeze into the day, physicians are having to adjust how they practice medicine. "This is really important in changing the mindset we've had in this country around healthcare, which is to stop focusing so much on treatment after people get sick and focusing instead on health promotion and prevention," Young says.

While a healthier population sounds like a laudable goal, the emphasis on value is placing new burdens on the healthcare system. One of the questions, of course, is how to measure value Metrics outlined in the creation of ACOs are meant to address this in part, but reporting infrastructure and requirements continue to be problematic.

"There's so much reporting, data collection, number crunching, documentation, interaction with patients designed to capture numeric information and metric information, and the typical independent physician who might be in a private practice increasingly doesn't have the scale, infrastructure or capacity to be able to meet those requirements," Northeastern's Hoff says.

Additionally, how can value be measured when patients become healthy and no longer require medical services? "This creates a lot of challenges for hospital executives who still need to fill their beds to some degree and have substantial numbers of employees," Young says.

ACOs are a value-based model, consolidating care and reducing duplicate services by sharing risks and savings. But working under a model that rewards results has its own stresses. In fact, a 2013 survey by Wolters Kluwer Health found that managing shifting payer reimbursement models is the most pressing business challenge among physicians.

Moreover, a 2015 study by Rand Corporation sponsored by the American Medical Association found that "financial incentives applied to physician practices via alternative payment models were not simply 'passed through' to individual physicians."

Independent practitioners are also increasingly partnering with other caregivers under a bundled payment system. With bundled payments, healthcare providers share a single payment for a range of services instead of each provider billing separately. This benefits the patient, because she can see what, exactly, she is paying for among a comprehensive set of services —and payers and providers share risk.

"If we look at it as a product and figure out a way to reduce all the different cost components and we have motivation to make money by getting the patient out quicker and healthier, and if we all come together as a team, won't it be better for the consumer to look at a single price for the whole

thing?" attorney Rust asks.

Under this system, however, there is a concern that physicians may lose some clinical autonomy when hospitals are in charge of bundling. Someone has to make decisions when it comes to determining how cases are managed and who is paid what, Rust says, and that's often the person at the top—the hospital CEO. "That's the vertical line, the consolidation of the industry," he says.

Physician Feedback

"Unintended consequences of this in a long run will be that no one will be willing to take care of sick patients, because they will cost the doctor money in reimbursement. Quality measurement should be whether or not the appropriate patient is advised to have a colonoscopy and whether or not the diabetic is told to take his medicine and lose weight. This is a very dangerous game that the government is playing with physician reimbursement and it will be the death of the small practice."

"Costs associated with building the infrastructure to report measures (some of which are dubious at best) are not offset bu gains in reimbursement. In the ideal situation of every provider meeting standards, there will be no extra money. Ultimately could just be a complicated way to cut reimbursement."

"A difficult chaff but coupled with ACOs adds opportunity to increase safety, quality and save cost."

"Let's start paying lawyers and politicians using a similar grading system."

"The emphasis has moved from the patient to the process."

"The problem is that this law does not reward good medicine, it only rewards good record keeping."

Analysis

One reason the data is slow to be added may be the way that physicians are sending their information to CMS. Some medical groups are using a clearinghouse or intermediary, third party to get it to the government, according to Joel Shalowitz, MD, MBA, FACP, professor of preventive

medicine at Northwestern University's Feinberg School of Medicine in Chicago, Illinois. "Sometimes those companies aren't doing their jobs, so it's delayed."

Many physicians feel that CMS should have waited to launch the site until after all the data is added and has been vetted for accuracy. "Physicians think CMS did not do enough to highlight the disclaimer that this is not comprehensive yet," De La Torre says.

In addition, many physicians are discouraged by high error rates in accuracy of their members' information. "The College of American Pathologists had like a 50% error rate for their members," Shalowitz says. "It might be indicative that the system isn't what it should be."

While inaccuracy alone is troubling, it's made more complex by the fact that physicians will receive a 2% penalty on Medicare/Medicaid payments for not reporting their most up-to-date information to CMS, regardless of whether physicians themselves or a third party sent it. The data submission period closed in November 2015, but penalties are assessed retroactively in two-year increments, so 2016 penalties are based off of 2014 reporting, and so on until and unless new rules are announced.

The American Medical Association and other physicians groups are especially unhappy with the forthcoming fines, De La Torre says. "If the data is incomplete or wrong, they feel it's unfair." He predicts that many physicians will challenge those fines in the coming year.

CMS faces a challenge in creating performance standards for the website that are fair and accurate to all physicians across different specialties and sizes of practice. "The data could be timely and accurate, but not meaningful," Shalowitz says.

He posits a hypothetical situation in which two doctors perform the same procedure, but in different size practices, with different degrees of challenge. The numbers might show a higher morbidity rate for one doctor because he has a smaller practice, or a larger number of sicker patients. "That data is worse than nothing because it would steer people to the wrong place," Shalowitz says.

Others wonder how likely consumers are even to use the website once it is completed. Shalowitz feels it hasn't been up long enough, or with sufficiently complete information, for accurate analysis. "In my 15 years of experience, most people don't make use of objective information in making their healthcare decisions. It's more often word of mouth," he says.

While there is some evidence that people pay attention to report cards, De La Torre says, "in general people say healthcare is too complicated, or the quality is not great, but they give their own physicians higher ratings."

Practices and physicians had a 30-day window to approve their data before it went live on the Physician Compare website, but that review process ended in November, 2015. Physicians who didn't review their information will see it go live anyway, without an appeals process, according to the CMS website.

For physicians hoping CMS might take down the website due to widespread provider dissatisfaction, De La Torre says that's unlikely. "CMS is not going to back down," he says. "This is the path we're heading down."

Physician Feedback

"We need a site for insurance companies and congressmen as well."

"This website constitutes CMS's engagement in cyberbullying practicing physicians."

"... My incentive is the patients under my care. My patients refer their friends and family to me—that referral matters more to them than some kind of grade on a website."

"Penalizing physicians is not a way to encourage better healthcare. Incentives are great for doctors

and patients alike, but punitive measures are for the court system, not the legislative body."

"The site is not accurate and getting information corrected is next to impossible even when multiple documents are submitted. It appears to be at random and not vetted at all."

"Not all that is important can be measured, and not all that is measurable is important."

"[The site is] horribly inaccurate."

"Garbage in equals garbage out."

"Physician Compare does not adequately measure true 'quality' in taking care of patients."

Expansion of health IT

GRADE: 31 = F

The HITECH Act set the electronic ball rolling in 2009 and CMS introduced its electronic health record (EHR) meaningful use program in 2010. Still, the question remains whether health IT has improved patient care through a secure, interoperable nationwide health information network enough to offset the added burden to physicians' practices, as the government promised at the time.

The Affordable Care Act further encouraged physicians to make the transition from paper to digital records to improve patient care and physician communication.

Analysis

Though a Merritt Hawkins study of 650,000 American physicians found that 85% of physicians have adopted EHRs since 2012, 46% felt that EHRs detract from their patient care. The reporting requirements have proven to be a barrier for many physicians even to obtain the incentives in the first place. Carrie Nixon, JD, says that the most up-to-date numbers, from 2013, show that out of 1.25 million eligible providers, 450,000 did not submit the data to qualify for incentives. That resulted in a loss of 1.5% of the total reimbursement, which she calls "a pretty significant amount."

"I think most physicians would say that [EHR incentive programs] have had a negative impact because they are having a difficult time getting their arms around the reporting requirements," she says. "They'll tell you it's taking away from time to care for their patients."

Even for physicians who have been able to use their EHRs without many problems, and successfully attest to Meaningful Use, the software has a ways to go before it becomes intuitive. "The ACA encouraged coordinated care but the tools we have don't do a very good job of that because they are dealing with layers of segregated data," says Robert Rowley, MD, a family physician and health IT consultant in Hayward, California.

The move to coordinated care is a positive development that might not have happened without the legislative push of the ACA, Rowley says, but the EHR vendors haven't caught up. The tool he uses to chart and bill patients in his own practice, has taken him nine months to master.

Others believe expansions in health IT have been more positive than negative and just need time. "It's allowed information transfer to occur more quickly across the system," Hoff says. He also sees health IT as especially useful for

population-based healthcare and spotting patients who need extra attention more quickly. “It allows much better documentation in some ways…so it provides greater transparency as a whole,” he says.

The transition to electronic data also has helped physicians save money by getting rid of paper charts and their concomitant need for storage and retrieval. “One nice thing is you don’t have to look for a chart, which is a big savings on time and hence money,” Feinberg School of Medicine’s Joel Shalowitz says.

However, he also thinks that the shift away from written notes has negatively impacted patient care. Now, providers spend more time checking off boxes than writing an effective narrative. “You don’t get the feel of what happened with the patient, and that’s a big problem,” Shalowitz says. Still, given that physicians report spending 20% of their time on non-clinical paperwork, it’s unlikely that they will be inclined to return to paper-based charting.

Hoff says that many physicians see technology “as this evil device that’s enabling them to be watched over and have their work controlled.” He points to the Merritt Hawkins’ physician satisfaction survey, saying, “At the heart of a lot of discontent right now is all the metrics that are placed on them. Medicine is becoming one big cookbook of measurements.”

Nixon suggests that all of these early frustrations are just “growing pains” and that once physicians are used to and have incorporated them into their daily practice, “work flow will become easier, second nature.”

Other changes in technology that hold promise for the future include telemedicine, in which patients can meet virtually with doctors, thereby providing access for patients who can’t easily get to their doctors. “It’s good for the patient because they can maybe get contact with their regular physician, and it’s good for the doctor to have continuity with an established patient relationship,” Hoff says.

Of course, physicians are concerned about how they will be paid for such visits. “I hear doctors ask all the time, what’s the business model for that going to be, what’s reimbursement going to be like, because traditionally those kind of visits have been undercompensated,” Hoff says.

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Ultimately, it’s impossible to tease apart how much new health IT has been the result of the ACA and how much would have taken place anyway. “All of these things are very much tied together,” Shalowitz says, “You can’t just say the ACA flipped a switch.”

Physician Feedback

“It is not ready for prime time. This is th single most detrimental hurdle to practicing.”

“Nothing ruins a patient's experience faster than a computer in the exam room.”

“The idea was good but the incentives were never meant to offset the ongoing cost increase to implement EHR use and maintenance. I think that just opened doors to lots of IT vendors who are overcharging because they can!”

“EHRs are clearly beneficial for patients—things are more organized. EHRs are still in an early stage and hopefully will get better for docs, especially in connectivity between systems....”

“E-prescription efficiency and accuracy is wonderful. Printing a legible plan for the patient is wonderful. Legible consults and record are wonderful. But ... everything involved in patient care takes longer.”

“I use an EHR and like it. I have to be careful not to get stuck looking at my screen and not the

patient. I think it is a useful way to organize my patient's records without clutter. Is the quality of care better? I am not sure."

"The EHR is the single worst thing among many to happen to medical practice in the past 15 years."

"My EHR cost over $75,000, not counting the hundreds of hours invested by my staff and I to make it work. I will never recover that investment."

"There needs to be seamless, user-friendly interoperability, but the costs associated need to be very low so those of us in small private practices can afford it."

"Some EHR functionality is very helpful, but I spend a large amount of time as a clerk. Thank you 9th grade typing teacher!"