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PAY FOR PERFORMANCE OR COMPLIANCE? A SECOND OPINION ON MEDICARE REIMBURSEMENT

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S. Luke Leininger

> 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, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.
>
> — Social Security Act[1]

There is good news and bad news on Medicare reimbursement. The good news is that Members of Congress are unhappy with the Medicare physician payment program that they created. It is a complex system of administered pricing and price controls, governed by elaborate statutory formulas and characterized by mind-numbing regulatory micromanagement. In sharp contrast to reimbursement for professional services in other economic sectors, Medicare providers are not paid according to their skill levels, their innovative treatments, the quality of the care delivered to individual Medicare patients, or the specific benefits provided to patients. Moreover, under current government formulas, they can look forward to future reductions in Medicare reimbursement even though they are expected to treat a dramatically larger Medicare population.

Needless to say, most physicians are unhappy with Medicare's payment system—a view increasingly shared by senior Members of Congress. House Ways and Means Committee Chairman Bill Thomas (R–CA) and Health Subcommittee Chairman Nancy Johnson (R–CT) have said, "It is time to change this irrational system."[2]

The bad news is that, instead of enacting real reform, Congress is preparing not only to keep Medicare's rigid system of price controls and central planning, but also to add another layer of regulatory control over physician behavior. Senate Finance Committee Chairman Charles Grassley (R–IA) and Ranking Member Max Baucus (D–MT) sponsored the Medicare

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1. 42 U.S.C. § 1395 (2006).

2. *Reps. Thomas, Johnson Ask for CMS Help in Changing Medicare's "Irrational" Payment System*, WASH. HEALTH POL'Y WEEK IN REV., June 27, 2005, *available at* http://www.cmwf.org/healthpolicyweek/ (last visited May 19, 2006).

Value Purchasing Act of 2005 (S. 1356)[3], which would implement "pay for performance" in the Medicare program by tying physician payment to compliance with government-defined medical guidelines. Representative Johnson introduced a similar bill in the House. The approach is well intentioned, but more central planning will only intensify the Medicare reimbursement problem, not ameliorate it.

I. A MISGUIDED APPROACH

The concept of "pay for performance" in Medicare is unquestionably attractive to federal policymakers and suggests—correctly in our view—that Medicare patients and the taxpayers are not getting the best value for their money. Using the rhetoric of "best practices" and "evidence-based medicine" to describe this approach, proponents are creating the false impression that new government guidelines would promote market-like competition, control costs, and improve the quality of health care delivered within Medicare. They believe that adopting this approach would simultaneously control the growth of Medicare costs in a more rational fashion and close the gap "between the health care we now have and the health care we could have."[4]

Before succumbing to the latest health care policy fad, Members of Congress should carefully consider two things: the likely impact of government incentives designed to secure physician adherence to centrally determined standards and whether or not those standards can indeed provide higher quality to patients and better value to taxpayers. Despite the rhetoric to the contrary, this proposal is anything but a free-market approach to physician payment. It is, in fact, a compliance-based system, inherently burdened by serious limitations. For example, such a system would:

- Dump patients into a system of top-down, "cookbook" medicine that is incompatible with high professional standards of patient care;
- Spawn an increasing number of Medicare rules, regulations, and guidelines, further undercutting the physician's professional autonomy and integrity, as well as patient choice and access to care;
- Undermine the more desirable goal of high quality, which requires personalized care;
- Retard medical innovation and introduce unproductive gaming by doctors to secure higher Medicare reimbursement; and
- Further weaken the traditional doctor–patient relationship.

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3. Senator Chuck Grassley, Statement Upon Introduction of the Medicare Value Purchasing Act of 2005 (June 30, 2005), *at* http://www.himss.org/Content/files/Medicare6-30-05_floor_statement.pdf (last visited May 19, 2006).

4. INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY (2001) [hereinafter CROSSING THE QUALITY CHASM].

II. A BETTER POLICY

If Members of Congress had seized the opportunity to replace the current Medicare system with a premium support program similar to the Federal Employees Health Benefits Program ("FEHBP") during consideration of the Medicare Modernization Act of 2003, they would not now need to fix the Medicare physician payment system that they created. The FEHBP is characterized by consumer choice, market competition, and minimal bureaucracy and regulation. The Office of Personnel Management, which administers the FEHBP, does not prescribe detailed formulas for physician payment for thousands of medical services, enforce price controls, or conduct compliance audits or investigations into physician payment.

However, short of serious and comprehensive Medicare reform, Congress should go back to the drawing board and design a new reimbursement system for Medicare doctors, combined with reliable market-based updates for physicians' services. Meanwhile, Congress should:

- Abolish the current fee schedules and the update formulas;
- Eliminate Medicare restrictions on balance billing (effectively a price control system) and allow doctors to charge either more or less than the Medicare fixed price for medical services; and
- Require physicians, as a condition of participating in Medicare, to disclose the prices that they charge for Medicare services.

As a national market develops, private-sector organizations (e.g., consumer, professional, and seniors' groups) could generate information on the quality of health care services, meeting the market demand for quality information.

III. THE CURRENT MEDICARE REIMBURSEMENT SYSTEM

Medicare's current reimbursement policy is a complex, formula-driven system of administrative pricing, central planning, and price controls.[5] It has

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5. Since the early 1980s, Congress has tried repeatedly to solve the growing problem of rapidly rising Medicare expenditures by imposing complicated and progressively tighter systems of administrative pricing for hospital and physician services. In 1983, with the support of the Reagan Administration, Congress adopted a prospective payment system ("PPS") for Medicare payment to hospitals, fixing the prices of hospital services according to the average cost of treating specified diagnoses. In 1989, Congress created the RBRVS system for physician reimbursement. In 1997, Congress expanded the PPS system for a variety of non-physician Medicare providers. *See generally* Ctrs. for Medicare & Medicaid Servs., http://www.cms.hhs.gov/ (last visited May 20, 2006).

three main features: the fee schedule, updates and controls, and balance billing restrictions.

A. The RBRVS Fee Schedule[6]

Medicare uses the resource-based relative value scale ("RBRVS") to pay for physician services. Under this formula, Medicare officials compute the "objective value" of an estimated 7,000 procedures.[7] Each component of a medical service is assigned a weighted value that is calculated by using social science measurements of the time, energy, and effort required to perform a given procedure, including resource inputs such as medical equipment, malpractice insurance, and administrative costs. These weighted "values" are then converted into dollar amounts and used to determine the fees that Medicare pays to physicians for those services.[8] The diagnosis related group ("DRG") system reimburses hospitals using a similar strategy.[9]

B. Updates and Controls

Attempting to limit Medicare physician costs, Congress also created volume controls, based on an official projection of the "appropriate" growth rate of Medicare physician services. Since 1997, these volume controls have been tied to the Sustainable Growth Rate ("SGR"), the congressionally created formula for determining annual updates in physician reimbursement rates under the Medicare fee schedules. Under the SGR, the annual update in reimbursement is linked to the aggregate level of Medicare spending for physician services. If spending exceeds the government target, which is based

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6. Altogether, Medicare uses eleven different fee schedules and PPS arrangements to establish the prices paid to over one million providers for treating Medicare patients. Letter from the Ctrs. for Medicare and Medicaid Servs. Adm'r Mark McClellan, to the House Ways and Means Comm. Chairman William Thomas (June 24, 2005) (on file with author).

7. For more information about the RBRVS, *see* Kevin Hayes, *Medicare's Payments for Physician Services*, MEDICARE PAYMENT ADVISORY COMM'N (MEDPAC) (Feb. 14, 2003), *at* http://www.medpac.gov/publications/congressional_reports/Physicians_KH.pdf (last visited May 19, 2006). For a critical evaluation of the RBRVS, *see* Robert E. Moffit, *Back to the Future: Medicare's Resurrection of the Labor Theory of Value*, 15 REG. 54, 54-63 (1992), *available at* http://www.cato.org/pubs/regulation/reg15n4f.html (last visited May 19, 2006). *See also* REGULATING DOCTORS' FEES: COMPETITION, BENEFITS AND CONTROLS UNDER MEDICARE (H.E. Frech III, ed., 1991).

8. Robert E. Moffit, *Why Doctors Are Abandoning Medicare and What Should Be Done About It*, HERITAGE FOUND. BACKGROUNDER NO. 1539, Apr. 22, 2002, at 5, *available at* http://www.heritage.org/Research/HealthCare/BG1539.cfm (last visited May 19, 2006).

9. For more information about the DRG hospital payment system, *see* MEDICARE PAYMENT ADVISORY COMM'N, REP. TO CONGRESS: MEDICARE PAYMENT POLICY, at 43–44 (Mar. 2005), *available at* http://www.medpac.gov/publications (follow "more Publication" hyperlink; then follow "Reports" hyperlink) (last visited May 19, 2006).

on growth in the national economy, a statutory algorithm reduces the increases in the reimbursement rate.

The SGR system has been ineffective in controlling volume—the volume of physician services per beneficiary rose by almost twenty-two percent between 1999 and 2003[10]—while creating new problems for physician reimbursement. The Centers for Medicare and Medicaid Services ("CMS") recently reported that Medicare's sharp 15.2% increase in spending for physician services in 2004 was due almost entirely to volume growth. The result was a scheduled 4.3% cut in physician reimbursement rates, beginning January 1, 2006.[11] CMS actuaries are projecting similar negative payment updates of five percent annually for the next seven years, which means that physician payments would decrease by more than thirty-one percent from 2005 to 2012. During the same period, physician practice costs would go up by nineteen percent.[12]

As doctors find it financially burdensome to treat Medicare patients, they will stop accepting new ones. According to a recent American Medical Association survey, thirty-eight percent of physicians will reduce the number of new Medicare patients that they see as a result of the impending 2006 cuts.[13] More than one-fifth of Medicare enrollees already have trouble finding a primary care physician, and twenty-seven percent report delays in getting an appointment, according to a recent Medicare Payment Advisory Commission ("MedPAC") study.[14]

There are several reasons for the SGR's inability to control volume. For one, the growth rate of the national economy (as measured by GDP) has very little to do with the growth rate of services, making it a poor benchmark for a spending target. For example, during a recession, the spending target is pushed downward, punishing physicians, even though practice costs and demand for services do not drop proportionally. In fact, the growth in Medicare spending is driven largely by new technology, patient needs, and public policies related to the provision of services. These factors are outside the direct control of physicians, making them useless targets for volume control incentives.

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10. *Id.*

11. MEDICARE PAYMENT ADVISORY COMM'N, ISSUES IN A MODERNIZED MEDICARE PROGRAM, at 198 (June 2005), *available at* http://www.medpac.gov/publications (follow "more Publication" hyperlink; then follow "Reports" hyperlink) (last visited May 19, 2006).

12. Letter from William Thomas, House Ways and Means Comm. Chairman and Nancy L. Johnson, Chairman, Subcomm. on Health, to Ctrs. Medicare and Medicaid Servs. Adm'r Mark McClellan (July 12, 2005) (on file with author).

13. Am. Med. Ass'n, *AMA Member Connect Survey: Medicare Payment Cuts Will Hurt Access to Care,* http://www.ama-assn.org/ama/pub/category/14925.html (last visited May 19, 2006).

14. Am. Med. Ass'n, *Medicare Physician Payment: The Facts*, http://www.ama-assn.org/ama1/pub/upload/mm/399/nac_ppfacts.pdf (last visited May 19, 2006).

Moreover, even if physicians did exert a large degree of control over Medicare spending, individual doctors cannot be expected to respond to collective incentives. An aggregate spending target and universally applied rate update will not decrease (and may even increase) the short-run incentives for individual physicians to increase volume, because they know that any personal effort to reduce services would not result in a proportional increase in payments.[15]

C. Balance-Billing Restrictions

The third feature of Medicare's current reimbursement policy is the restriction on balance billing, the amount charged by a provider to a patient above what Medicare is willing to reimburse. With the enactment of the Balanced Budget Act of 1997, Congress imposed new legal obstacles to private contracts for services performed on Medicare recipients, cutting off an escape route for doctors and patients who might want to enter into a private payment system outside the Medicare program.[16] Meanwhile, providers must incur losses because of inadequate reimbursement for Medicare services[17], and they do not have the flexibility to adjust prices to attract new business or react to market challenges and opportunities. By removing any remnant of a price mechanism, balance-billing restrictions compound the inefficiencies of the Medicare physician payment system and stifle improvements in quality and value.

In summary, Medicare pays doctors according to a resource-based formula that embodies an "objective" theory of value that is utterly inconsistent with modern economics, combined with inefficient price regulation and an illogical reimbursement update formula. The current Medicare fee schedule does not and cannot account for differences in physicians' skills, quality of service, and benefit to the patient any more than a physician can account for the state of the national economy. While common sense would dictate abolishing this outdated approach in favor of a rational system of market pricing, Congress is instead preparing to impose another layer of regulatory compliance on physicians.

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15. Moffit, *supra* note 8, at 5-6.

16. Under the terms of Section 4507 of the Balanced Budget Act of 1997, any doctor who enters into a private contract with a Medicare enrollee to provide services outside of the Medicare system is prohibited from billing Medicare for two years for any patients. Since 1997, the terms and conditions of these relationships have been further codified through regulation and litigation. For an excellent overview of this issue, *see* JOHN S. HOFF, MEDICARE PRIVATE CONTRACTING: PATERNALISM OR AUTONOMY? (1998).

17. David Glendinning, *AMA to Write Balance-Billing Legislation*, AM. MED. ASS'N NEWS, July 11, 2005, *available at* http://www.ama-assn.org/amednews (subscription required) (last visited May 20, 2006).

IV. THE GENESIS OF PAY-FOR-PERFORMANCE REIMBURSEMENT

Health policy experts who advocate pay for performance in provider reimbursement invariably rely on the concept of evidence-based medicine ("EBM"). Originally developed in the 1970s and 1980s by clinical epidemiologists at McMaster University in Canada, EBM is an attempt to apply epidemiological principles to clinical care and promote reliance on research data, particularly randomized controlled trials ("RCTs"), in the practice of medicine.[18]

In a performance-based reimbursement system, EBM is used to develop "clinical practice guidelines" and compensate health care providers according to their compliance with the "best practices" dictated by a third party's interpretation of RCTs. Health maintenance organizations ("HMOs") seized upon this concept in the 1990s, employing strict practice rules to override the clinical judgment of the treating physician in order to control utilization and limit costs. In practice, they used guidelines to rule instead of to guide, stressing evidence-based guidelines to the exclusion of clinical judgment.

Despite provoking a backlash from physicians and patients during the mid to late 1990s, practice guidelines continued to be developed for physician practice at a rapid rate. According to one estimate, more than 1,000 guidelines are being developed annually by quality-of-care organizations, medical associations, and health insurance plans.[19]

Those who advocate tying clinical guidelines to financial compensation through pay-for-performance reimbursement claim that it will narrow the gap between "ideal," cost-effective care and actual care observed in clinical settings. In their view, financial teeth are needed to motivate physicians to standardize their treatment decisions. They believe that this would reduce medical errors, optimize quality of care, and control escalating health care costs by controlling price and utilization more directly.[20]

A. Enter Medicare

The Centers for Medicare and Medicaid Services obtained the authority to experiment with pay for performance in Medicare from the Medicare Modernization Act of 2003 and the Medicare, Medicaid, and SCHIP Benefits

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18. R. Brian Haynes, *What Kind of Evidence Is It That Evidence-Based Medicine Advocates Want Health Care Providers and Consumers to Pay Attention to?*, 2 BMC HEALTH SERVS. RES. 3 (Mar. 6, 2002), *at* http://www.biomedcentral.com/1472-6963/2/3 (last visited May 20, 2006).

19. Stefan Timmermans & Aaron Mauck, *The Promises and Pitfalls of Evidence-Based Medicine*, 24(1) HEALTH AFF. 18, 19 (2005).

20. CROSSING THE QUALITY CHASM, *supra* note 4; Nat'l Comm. for Quality Assurance, *The State of Health Care Quality: 2004*, *at* http://www.ncqa.org/communications/SOMC/SOHC2004.pdf (last visited May 20, 2006).

Improvement and Protection Act of 2000.[21] The agency has established eight demonstration initiatives: two address the quality of clinical care in hospitals, three deal with physician offices and integrated health systems, and three test specific models of chronic care improvement and disease management.[22]

The Premier Hospital Quality Incentive ("PHQI") demonstration, the most advanced initiative, is designed to track and reward performance in treating five chronic health conditions at 270 hospitals around the country.[23] Provider compliance with a uniform set of thirty-four quality indicators yields significant financial rewards for participating providers, and failure to follow them adequately leads to decreased compensation. While it will be several years before conclusions can be drawn from even this first demonstration, CMS did release a round of tentative first-year results in May, showing an average increase in the composite quality score of participating hospitals from seventy-nine percent to eight-six percent.[24]

While seemingly impressive, however, these preliminary results do not constitute evidence of improved quality, but rather of increased compliance. The composite quality score is merely a measure of the percentage of the time that hospitals followed treatment instructions in pursuit of a financial bonus.

B. Triumph of Process

Although the score does contain two components, a process score and an outcome score, it is heavily weighted toward recommended processes, not outcomes. Of the thirty-four quality indicators in the hospital demonstration, twenty-seven measure compliance with dictated processes, while only seven measure outcomes like mortality or readmission rates.[25]

The Physician Group Practice Demonstration, which began in April of this year and is the first major Medicare pay-for-performance initiative to concentrate on physicians, similarly focuses on process over outcome. According to the demonstration design report, "The major focus of the

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21. Ctrs. for Medicare and Medicaid Servs., *Medicare "Pay for Performance (P4P)" Initiatives*, http://www.cms.hhs.gov/media/press/release.asp?Counter=1343 (last visited May 20, 2006).

22. *Id.*

23. Press Release, Ctrs. for Medicare and Medicaid Servs., Medicare Pay-for-Performance Demonstration Shows Significant Quality of Care Improvement at Participating Hospitals (May 3, 2005), *at* http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1441 (last visited May 20, 2006).

24. *Id.* This is the average of reported composite score improvements for each of the five chronic conditions.

25. Outcome measures represent only 50% of the hip and knee replacement score, 37.5% of the coronary artery bypass graft (CABG) score, 11% of the acute myocardial infarction (AMI) score, and zero percent of the pneumonia and heart failure scores. Ctrs. for Medicare and Medicaid Servs., *CMS HQI Demonstration Project: Composite Quality Score Methodology Overview*, *at* http://www.cms.hhs.gov/HospitalQualityInits/downloads/HospitalComposite QualityScoreMethodologyOverview.pdf (last visited May 20, 2006).

demonstration will be on measuring process indicators of quality. They are the indicators most easily measured."[26] They may be the most easily measured, but are they the most indicative of quality care?

Thus, despite the relative lack of objectivity and flexibility, Medicare's demonstrations rely primarily on process mandates rather than outcome measures to implement pay for performance. David M. Eddy, Senior Advisor for Health Policy and Management at Kaiser Permanente, acknowledges that "a process measure, by its very nature, micromanages. Instead of leaving plans free to set their own priorities for improving health outcomes, a process measure tells plans precisely what their priorities should be."[27] Even if outcomes were used exclusively, the process of choosing which outcomes to include and deciding the relative importance of each outcome would necessitate deference to the values, perspectives, and agenda of the policymaker.

C. Congressional Action

Bipartisan congressional efforts are now underway to move Medicare beyond demonstrations into a full-scale pay-for-performance reimbursement system. CMS Administrator Mark McClellan appears determined to move ahead with a Medicare pay-for-performance expansion under the regulatory prerogatives of his agency. He is making the effort one of his top priorities and recently speculated that within the next five to ten years, performance-based compensation could comprise up to thirty percent of the government's payments to providers.[28]

Any national Medicare pay-for-performance payment system will likely be similar to the CMS demonstration initiatives, emphasizing process over outcome and rewarding compliance with centrally defined practice guidelines. Preliminary reports indicate that the proposed legislation would pay for compliance-based bonuses by withholding up to two percent of regular reimbursements from all physicians.[29] In other words, most doctors would receive less so some could receive more. This is not quality-based compensation; it is redistribution of income toward those providers who subordinate their judgment and creativity to the mandated protocols most successfully.

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26. Gregory C. Pope et al., *Physician Group Practice (PGP) Demonstration Design Report, at* http://www.cms.hhs.gov/healthplans/research/PGPDemoRpt.pdf (last visited Aug. 30, 2005).

27. David M. Eddy, *Performance Measurement: Problems and Solutions*, 17(4) HEALTH AFF. 7, 18 (1998).

28. Cal. Healthcare Found., *Pay-For-Performance Programs Draw Mixed Reviews*, http://www.ihealthbeat.org/index.cfm?Action=dspItem&itemID=105722 (last visited May 20, 2006).

29. E-mail from Renal Physicians Ass'n, to RPA Members (July 15, 2005), *at* http://www.renalmd.org/blastemail/july05.html (last visited May 20, 2006).

Because of Medicare's vast size, the change would reverberate throughout the private payer system, compounding its effect. With almost forty-two million enrollees and $290 billion in annual expenditures, which will dramatically increase in 2006 when the Medicare Part D drug entitlement takes effect, Medicare is the largest purchaser of health services in the United States.[30] In an open letter published in *Health Affairs*, Medicare pay-for-performance advocates point out that "a major initiative by Medicare to pay for performance can be expected to stimulate similar efforts by private payers, just as Medicare's adoption of prospective payment for hospitals did two decades ago."[31]

V. PROBLEMS OF THE MEDICARE PAY-FOR-PERFORMANCE PROJECT

Before launching Medicare into a pay-for-performance program, Congress should consider the problems that will necessarily arise out of a Medicare payment system that requires adherence to centrally defined protocols. Congress cannot safely ignore these difficulties.

A. Problem #1: Limitations of Evidence-Based Medicine

The gold standard of evidence in evidence-based medicine is a combination of double-blind, randomized, controlled trials and a systematic review of medical studies called meta-analysis. Although it is conceptually attractive because of its appeal to statistics, no evidence supports overriding the treating physician's medical decisions with RCT-based guidelines issued by a third party who has never even seen the patient. In 2004, the Agency for Healthcare Research and Quality ("AHRQ") in the U.S. Department of Health and Human Services reviewed the literature related to the efficacy of EBM-based compensation, which it referred to as "quality-based purchasing." The review found "only nine randomized controlled trials" and concluded that "little unequivocal data" supported this approach.[32]

The premise of RCTs as objective verification of "best practice" encounters several other serious conceptual problems. First, RCTs can conflict with one another. In July 2002, scientists conducting the Women's Health Initiative found that Preempro, a hormone replacement therapy drug, had risks of heart attacks exceeding its benefits. These results directly contradicted the results of several other previous and ongoing RCTs, which showed a reduced

30. Henry J. Kaiser Family Found., *Medicare at a Glance*, http://www.kff.org/medicare/upload/7305.pdf (last visited May 20, 2006).

31. Berwick et al., *Paying for Performance: Medicare Should Lead*, 22(6) HEALTH AFF. 8, 10 (2003).

32. R.A. Dudley et al., *Strategies to Support Quality-based Purchasing: A Review of the Evidence*, http://www.ahrq.gov/clinic/epcsums/qpurchsum.pdf (last visited May 20, 2006).

risk of heart disease associated with the drug.[33] According to Dr. R. Brian Haynes, chief of the Health Information Research Unit at McMaster University and one of the originators of EBM, "It is difficult to be smug about the superiority of the research methods advocated by EBM when the results of studies that are similar methodologically not infrequently disagree with one another."[34]

EBM's usefulness as the primary benchmark for treatment decisions is also questionable because RCTs can address only limited medical issues. Despite the massive amount of medical literature published every year, legitimate RCTs cover only a small number of conditions and procedures. Almost all are conducted over only a few months or years, leaving the long-term consequences of a therapy undetected.[35] According to Dr. Nuala Kenny, founder of the Department of Bioethics at Dalhousie University in Canada, "Scientific data cannot be expected to guide most medical decisions directly. There are not enough randomized trials or epidemiologic studies."[36] To develop guidelines, developers often must depend upon some studies conducted on relatively small and unrepresentative populations. As a result, explains Dr. Alan M. Garber of Stanford University's School of Medicine, "Guideline authors nearly always extrapolate to groups that were not adequately represented in the trials."[37]

Interestingly, early proponents of evidence-based medicine understood its weaknesses and never meant for it to be more than one factor in a "multi-faceted clinical decision-making decision process."[38] According to Dr. Haynes:

> [E]vidence from research can be no more than one component of any clinical decision. Other key components are the circumstances of the patient (as assessed through the expertise of the clinician) and the preferences of the patient. Just how research evidence, clinical circumstances, and patients' wishes are to be combined to derive an optimal decision has not been clearly stated, except that clinical judgment and expertise are viewed as essential to success.[39]

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33. Gina Kolata, *Hormone Studies: What Went Wrong?*, N.Y. TIMES, Apr. 22, 2003, at F1.

34. Haynes, *supra* note 18, at 5.

35. Mary E. Tinnetti et al., *Potential Pitfalls of Disease-Specific Guidelines for Patients with Multiple Conditions*, 351 NEW ENG. J. MED. 2870, 2870-74 (2004).

36. Nuala P. Kenny, *Does Good Science Make Good Medicine?*, 157 CAN. MED. ASS'N. J. 33, 34 (1997).

37. Alan M. Garber, *Evidence-Based Guidelines as a Foundation for Performance Incentives*, 24(1) HEALTH AFF. 174, 176 (2005).

38. Aaron Michael Cohen et al., *A Categorization and Analysis of the Criticisms of Evidence-Based Medicine*, 73 INT'L J. MED. INFORMATICS 35, 35-43 (2004).

39. Haynes, *supra* note 18, at 4.

Thus, research evidence is just one of three decision points in the treatment process. The other two, to which "applied research is a complementary way of knowing," are clinical circumstances and patient preferences.[40] By using financial incentives to drive compliance with clinical algorithms, a Medicare pay-for-performance scheme would devalue these two aspects of medical decisions in favor of a prescribed list of procedures. In other words, it would produce the very "cookbook medicine" that those who conceived of EBM have denounced as a "misuse of evidence based medicine."[41]

B. Problem #2: Dangers of Replacing Patient Choice and Physician Autonomy with Central Planning

As Dr. David M. Eddy has observed, "It is not stretching things too far to say that whoever controls practice policies controls medicine."[42]

Since clinical research produces conflicting, questionable, and limited evidence, the decisions required to reconcile results, assign relative importance, and sift out bad research cannot be made without subjective human judgment. Ultimately, someone's values are reflected in treatment decisions, whether those values are those of the patient, the physician, or a third party. Bias is inherent in such judgments.

Bias is found in the production, interpretation, and application of pay-for-performance quality indicators. Researchers exhibit bias when deciding which areas of research to pursue, which previous research to reference, and how to conduct their experiments. Journal publishers exhibit bias when deciding which research to publish. Published research is then subject to interpretation by guideline creators, who exhibit bias when choosing which research to incorporate in their guidelines, resolving conflicting results, assessing research flaws, and transforming findings into rules that weight competing priorities.

According to a 2004 Institute of Medicine report, "There are gaps and inconsistencies in the medical literature supporting one practice versus another, as well as biases based on the perspective of the authors, who may be specialists, general practitioners, payers, marketers, or public health officials."[43] Unable to avoid bias, pay for performance cannot live up to the

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40. *Id.* at 3.

41. David L. Sackett et al., *Evidence Based Medicine: What It Is and What It Isn't*, 312 BRIT. MED. J. 71, 71 (1996).

42. David M. Eddy, *Clinical Decision Making: From Theory to Practice, Practice Policies—What Are They?*, 263 JAMA 877, 877-78 (2000).

43. PATIENT SAFETY: ACHIEVING A NEW STANDARD FOR CARE 158 (Philip Aspden et al. eds., 2003).

standards of objectivity claimed by those who support imposing their version of "doing the right thing" on the medical community.[44]

Members of Congress need to ask themselves this crucial question: Whose judgment and values do we want to control important decisions about our medical care? Pay for performance would give control to third-party insurance or government managers, who have no information about the unique conditions, health history, preferences, and personal values of the individual patient being treated by the individual doctor. The protocols of the distant government agency would in practice overrule the doctor's medical judgment and the patient's choices.

The impact of this control shift would be government micromanagement of medical care and a corresponding reduction in physician autonomy and patient choice.[45] Physicians would be compelled either to follow government treatment guidelines or to suffer financial consequences, regardless of whether a particular guideline is in the best interests of a particular patient.

Twila Brase, president of the Citizens Council on Health Care, warns that adopting a pay-for-performance program "will lead to a limited list of approved health care services—'best practices' as determined by the agendas and values of a small cadre of politically motivated, personally-biased individuals sitting around a table somewhere making treatment decisions far from the patient's bedside."[46] These "elite" decision makers would not even know the name of the patient, much less the patient's unique circumstances and values.

When made from a distance by budget-focused technocrats, treatment decisions are apt to focus as much on rationing as they do on quality improvement. Keith Syrett, professor of law at the University of Bristol, observes that "decision making by guideline offer[s] a means of scientifically depoliticizing the rationing debate."[47] Payers are able to create the impression that there is scientific legitimacy behind cost-based decisions to restrict patient access to medically necessary treatments.

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44. The third of five system strategies listed on CMS's Quality Improvement Roadmap, published in July 2005, explains the agency's intention to "Pay in a way that expresses our commitment to supporting providers and practitioners for doing the right thing." Ctrs. for Medicare and Medicaid Servs, *Quality Improvement Roadmap*, http://www.cms.hhs.gov/CouncilonTechInnov/downloads/qualityroadmap.pdf (last visited May 20, 2006).

45. Americans overwhelmingly prefer control of medical care to lie with themselves and their physicians. This was demonstrated in the fight over President Clinton's Health Security Act in 1993, which included, among other things, required clinical guidelines to manage utilization.

46. Twila Brase, *How Technocrats Are Taking Over the Practice of Medicine: A Wake-Up Call to the American People*, CITIZENS' COUNCIL ON HEALTH CARE POL'Y REP. 18 (2005), *available at* http://www.cchconline.org/pdfreport/EBM_Report_-_Ex_Summary.pdf (last visited May 20, 2006).

47. Keith Syrett, *A Technocratic Fix to the "Legitimacy Problem"? The Blair Government and Health Care Rationing in the United Kingdom*, 28 J. HEALTH POL., POL'Y L. 715, 728 (2003).

The American Medical Association ("AMA") expressed concern over such potential EBM-based rationing at its national meeting in June 2005. "There is a potential concern when there is another intent behind pay for performance," said AMA Trustee John Armstrong, M.D.[48] "Some so-called pay-for-performance programs are a lose/lose proposition for patients and their physicians, with the only benefit accruing to health insurers."[49] As with any health care system that employs top-down planning to ration health care, the ultimate effect will be to limit access to appropriate health care services according to priorities imposed by a centralized bureaucracy.

This should be considered in the context of medical malpractice. It is bad policy to empower a centralized bureaucracy to construct and determine which clinical algorithms are to be used and which practices are "best" while also excusing it from any "responsibility for the clinical consequences."[50] In reality, the ultimate responsibility remains with the treating physician, whose best medical judgment may dictate proceeding in one direction while the third-party algorithm forces the physician to go in another. This could produce adverse results for the patient, and it would further complicate the medical malpractice crisis that is deepening in many states of the union.

C. Problem #3: Undermining of Personalized Care by Population-Based Medicine

Health care providers treat individual patients, not statistically significant groups. What may be the best treatment for the group on average might not necessarily be the appropriate treatment for an individual patient. Enforcing uniform clinical guidelines on patients whose conditions and values are anything but uniform is like trying to dress everyone in average-sized clothes regardless of their particular sizes and preferences.

Medical treatment decisions depend on a combination of factors—such as age, ethnicity, genetic background, severity of disease, comorbitidies,[51] and patient values—which physicians must incorporate into their evaluation of a patient's treatment options. The Medicare population is especially heterogeneous because of the prevalence of multiple illnesses in the elderly. Twenty percent of Medicare beneficiaries have five or more chronic conditions, and fifty percent are receiving five or more medications.[52]

Accordingly, Congress should question the appropriateness of using financial incentives to impose population-based clinical results on individual

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48. Mark Moran, *Pay for Performance Must Be Quality Issue, AMA Says*, 40 PSYCHIATRIC NEWS 9, 9 (2005).

49. *Id.*

50. Brase, *supra* note 46, at 2.

51. Comorbidities are defined as concurrent but unrelated medical conditions. STEDMAN'S MEDICAL DICTIONARY (28th ed. 2006).

52. Tinnetti, *supra* note 35, at 2870.

patient care. One study of 1,755 Type 2 diabetics found a twenty-four percent rate of noncompliance with clinical guidelines by internists. Far from finding a deficiency in quality, the researchers found instead "a deficiency in the definition of what constitutes best practices."[53] Among the clinical guidelines were periodic retinal eye exams and urine protein screens for microalbuminuria. Many physicians questioned the usefulness of the urine screen for patients already receiving ACE inhibitors, the indicated therapy for microalbuminuria. In another example of "noncompliance," some patients did not receive eye exams because they were blind. The authors concluded: "Our data suggest that failure to follow guidelines is not necessarily explained by 'bad doctors' or forgetfulness; rather, noncompliance may reflect valid questions about the usefulness and applicability of a best practice to an individual patient."[54]

In addition to limiting a doctor's ability to act in the best medical interest of an individual patient, one-size-fits-all clinical guidelines ignore the role of patient preferences and values in health care decisions. This is especially relevant to the Medicare population. Evidence shows that elderly patients with multiple conditions vary widely in their preferences regarding longer survival, disease prevention, quality of mental and physical functioning, level of inconvenience and pain, and risk of complication.[55]

A system of standardized treatment decisions is simply incompatible with the variability found in medicine. Even if it were possible to create evidence-based rules for every possible variation of patient characteristics and conditions, the sheer number of guidelines would be overwhelming and impossible to implement. Medical studies provide useful information about treatment options that may or may not work in a given situation, depending on the unique combination of circumstances involving the individual patient. However, the very nature of the statistical process, which minimizes bias and seeks mean tendencies, makes it insufficient to make the final decision for

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53. National Center for Policy Analysis, *Are "Best Practices" Always Best?*, http://www.ncpa.org/iss/hea/pd120601c.html (last visited May 20, 2006).

54. Christel Mottur-Pilson et al., *Physician Explanations for Failing to Comply with "Best Practices"*, 4 EFFECTIVE CLINICAL PRAC. 207, 212 (2001), *available at* http://www.acponline.org/journals/ecp/sepoct01/pilson.pdf (last visited May 20, 2006). For another illustration of the incompatibility of population-based guidelines with high-quality individualized care involving an example of colorectal cancer screening within the Veterans Administration, *see* Louise C. Walter et al., *Pitfalls of Converting Practice Guidelines into Quality Measures*, 291 JAMA 2466, 2466 (2004).

55. Tinnetti, *supra* note 35, at 2871. One study of 414 hospitalized patients eighty years old or older at four academic medical centers specifically measured health values of the elderly with respect to quantity vs. quality of life and other factors. The authors found that "Preferences varied greatly" and recommended: "Because proxies and multivariable analyses cannot gauge health values of elderly hospitalized patients accurately, health values of the very old should be elicited directly from the patient." Joel Tsevat et al., *Health Values of Hospitalized Patients 80 Years or Older*, 279 JAMA 371, 371 (1998).

every patient. Mathematical models or algorithms cannot capture that precise moment of human choice that is the essence of medical judgment.

Physicians must be free to use their best medical judgment to make clinical decisions that incorporate all relevant factors and available evidence. Appropriate medical decisions cannot be made using an assembly-line mentality that treats every patient like a generic commodity traveling down a conveyer belt.

As expressed by Dan Mendelson, president of the Health Strategies Consultancy in Washington, D.C., "Patients expect their doctor to tailor care to their individual condition, incorporating their medical history and preferences, the doctor's experience with similar patients, the most current research, and alternative therapies."[56] To do otherwise not only does a disservice to the patient, but also can ultimately increase morbidity and mortality, which in turn can increase the cost of Medicare.

D. Problem #4: Deterioration of Clinical Judgment and Medical Innovation

The fourth problem with a pay-for-compliance health care system is the deterioration of creativity, innovative ability, and medical judgment that will occur in an environment that devalues such qualities. With compensation hinging on adherence to guidelines, providers will become highly skilled at adhering to guidelines. In anticipation of a Medicare pay-for-performance shift, the growing "Medicare industrial complex" of lobbyists, lawyers, consultants, and professional "experts" who make a living deciphering and explaining the Medicare bureaucratese have already swung into action. Companies are already advertising "Pay-for-Performance Prep Guides," containing 400 pages of strategies to "ensure [that] your practice/organization succeeds with P4P [pay for performance]."[57]

As doctors treat the practice of medicine as if it were an SAT exam, with right and wrong answers and grades handed out by the government, their ability to be flexible, innovative, and discerning in patient care will suffer. Focused on the specific tasks that are linked to financial rewards, automatic practitioners of government-prescribed behaviors will replace doctors who are skilled in combining multiple sources of knowledge with their best medical judgment in providing patient care.

Medical students, interns, and residents will become trained in applying the third-party rules that govern their clinical decisions instead of developing keen clinical judgment and learning to constantly seek better ways to treat

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56. Dan Mendelson & Tanisha V. Carino, *Evidence-Based Medicine in the United States – De Rigueur or Dream Preferred?*, 24(1) HEALTH AFF. 133, 134 (2005).

57. Part B News and DecisionHealth, *Pay-for-Performance Prep Guide*, http://www.partbnews.com/tools/p4p/ (last visited May 20, 2006).

patients.[58] Proponents claim that this will "structure the environment in which care is delivered so that 'doing the right thing' becomes automatic."[59]

However, the "right thing" can differ from patient to patient and often changes over time. A 2001 study published in the *Journal of the American Medical Association* found that of seventeen clinical practice guidelines published by the Agency for Healthcare Research and Quality and still in circulation at the time, seven were in need of a major update, six required a minor update, and only three were determined to be valid. No conclusion was reached for the remaining guideline. Using survival analysis, the researchers found that about half of the guidelines were outdated in 5.8 years.[60] A health care system that ties reimbursement to sometimes outdated or low-quality guidelines would, at least occasionally, force providers to choose between financial compensation and their ethical duty to provide high-quality care. Even worse, it could produce physicians who do not know the difference.

Doctors reimbursed according to compliance will also lose the incentive and ability to innovate that has produced so many important medical advances. In the late 1960s and 1970s, Dr. Charles Kelman, an innovative ophthalmologist, challenged the entrenched "best practices" of his day and pioneered groundbreaking new methods of cataract surgery despite severe derision from colleagues. Dr. Kelman's innovative techniques revolutionized the field of cataract removal and ultimately became the standard by which all cataract surgeries are performed today. In fact, many consider him to be one of the greatest medical innovators because of the miracle that he wrought with cataract surgery and the millions of patients who have benefited from it.[61]

If government-instituted compliance mechanisms had been in place in the 1960s and 1970s, however, Dr. Kelman would have dared such innovation only at his own financial peril, because any deviation from the guidelines would have lowered his pay-for-performance scores. Unless we believe that today's medical practice has reached a state of perfection and is unlikely to be improved, it seems shortsighted to discourage similar advances in the future.

In the long run, automatic adherence to protocols is counterproductive. Physicians need to respond effectively to a changing medical world and unique patient challenges, but compliance-based payment systems would deprive them of the very ability to judge appropriate care and adapt with innovative methods of treating illness. Ultimately, the political negotiations

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58. Alan Muney, Oxford Health Plans, explains, "The purpose... [of evidence-based education] is to drive lifelong adherence to clinical practice guidelines resulting in improvement in the value of healthcare expenditures." Brase, *supra* note 46, at 3.

59. Kim A. Eagle et al., *Closing the Gap Between Science and Practice: The Need for Professional Leadership*, 22(2) HEALTH AFF. 196, 199 (2003).

60. Paul G. Shekelle et al., *Validity of the Agency for Healthcare Research and Quality Clinical Practice Guidelines: How Quickly Do Guidelines Become Outdated?*, 286 JAMA 1461, 1461 (2001).

61. Robert P. Gervais, *Cataract Surgery: A Lesson on "Best Practices,"* 15 AZMEDICINE 21, 25 (2004).

of bureaucrats and statisticians would replace the medical judgment of individual doctors and remove their incentive to do anything more than what is expressly required to earn their reward.

E. Problem #5: Poor Quality Because of Unproductive Gaming Behavior

In a letter published in the *New England Journal of Medicine*, Roy B. Verdery, Ph.D., M.D., claimed, "Economic incentives are always subject to 'gaming,' inappropriate manipulation of data, and 'cherry-picking' of patients.... Most physicians (and other professionals) work for rewards that are more important than money, including the respect of their patients and peers and the personal satisfaction of a job well done."[62]

By diverting the focus of doctors and other medical professionals from appropriate patient-centered medical care to superficial financial rewards, pay for performance will likely create incentives to game the system in several detrimental ways that may cause real quality to decline even while measured indicators are improving.

First, basing financial compensation on specific indicators leads to adverse selection. In other words, providers will tend to select relatively healthier patients who have a higher probability of complying with physician orders, achieving better outcomes, and thus improving the provider's bottom line.

Two recent studies on cardiologist report cards in New York illustrate this concern.[63] The first study looked at more than 80,000 patients from New York and Michigan and found that doctors in Michigan, which does not issue report cards, were more likely to perform angioplasties on very sick patients. The second, published in *Archives of Internal Medicine*, found that approximately eighty percent of New York cardiologists said that the system made them less likely to treat severely ill patients.[64] If selection is such a significant concern when information about physician performance is merely reported, one can imagine the impact when it is directly tied to compensation.

Compliance-based compensation could also encourage providers to falsify records to circumvent the system and provide needed care. One study found that thirty-nine percent of physicians already falsify insurance records to secure needed services for patients.[65] Government-endorsed, standardized medicine would magnify this problem.

Finally, if Congress ties money to specific medical interventions, doctors and other medical professionals will be pressured to focus on those

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62. Roy B. Verdery, *Paying Physicians for High-Quality Care*, 350 NEW ENG. J. MED. 1910, 1910-11 (2004).

63. Daniel Costello, *Rating Doctors: Who Benefits?*, L.A. TIMES, June 13, 2005, at F1.

64. Craig R. Narins et al., *The Influence of Public Reporting of Outcome Data on Medical Decision Making by Physicians*, 165 ARCHIVES INTERNAL MED. 83, 83-87 (2005).

65. Aspden, *supra* note 43, at 267.

interventions to the detriment of other important areas of medicine. Pay for performance's very premise is that financial incentives alter behavior. While very few doctors will allow them to completely consume their behavior, the nature of financial incentives will push them in certain directions. As a result, some conditions and some procedures will receive less than adequate attention.

"Inevitably... the dimensions of care that will receive the most attention will be those that are most easily measured and not necessarily those that are most valued," according to a recent study in *Health Affairs* on provider incentives.[66] Mitigating this problem would require increasing the number of required measurements, which would soon become overwhelming and counterproductive, even if there existed the possibility of doing so adequately. Thus, while adherence to measured indicators might show improvement, overall quality might become worse.

Instead of adjusting their behavior to a set of standard rules and guidelines, health care providers should be encouraged to meet their patients' needs and preferences in a comprehensive way. This cannot be accomplished in an arbitrary system of compliance-based incentives that encourages providers to manipulate the "game" to their financial advantage.

F. Problem #6: Further Weakening of the Doctor–Patient Relationship

"One major barrier to the adoption of EBM," according to analysts writing in *Health Affairs*, "is the overwhelming support for preserving the physician–patient relationship."[67] A Medicare pay-for-performance system would lead to a decline in this relationship. When patients understand that their physicians are being pressured to meet standardized treatment directives rather than to provide them with customized care based on their unique conditions and preferences, trust in their physicians will be compromised—and for good reason.

A 2003 study published in the *Journal of Ambulatory Care Management* showed that physicians operating under imposed financial incentives are much less likely to feel strongly that they can make clinical decisions in their patients' best interests without adverse financial consequences. Because of misaligned incentives, these physicians also feel less able to obtain medically necessary services for their patients.[68] Various studies have shown that such

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66. Meredith B. Rosenthal et al., *Paying for Quality: Providers' Incentives for Quality Improvement*, 23(2) HEALTH AFF. 127, 139 (2004).

67. Mendelson & Carino, *supra* note 56, at 134.

68. Jeffrey J. Stoddard et al., *Financial Incentives and Physicians' Perceptions of Conflict of Interest and Ability to Arrange Medically Necessary Services*, 26 J. AMBULATORY CARE MGMT. 39, 45 (2003).

patients understood and internalized the consequences of alternate payment methods and that this affects their level of trust in their health care providers.[69]

From the physician's perspective, the doctor–patient relationship changes dramatically when the patient's actions determine the physician's compensation. If the patient does not follow the physician's treatment plan, does not take medication as prescribed, or continues to engage in risky behavior, adverse results can occur. These will be reflected in the physician's rating and thus in the physician's pay-for-performance compensation. As physicians struggle with the demotivating reality of being held accountable for another person's behavior, which they do not control, their frustration levels will increase substantially, and they will come to see their patients as obstacles to overcome rather than as fellow human beings in need of care.

The doctor–patient relationship is crucial to patient care because high-quality health care hinges on personal trust. Medical decisions are complex, and patients do not have the level of expertise necessary to navigate them alone, so they must be able to trust their doctors with the most intimate information about their health condition. They trust their doctors to advise them on their most important decisions, matters of life and death, sickness and health. Combining full information and patient trust, physicians can provide the information and guidance needed to make good decisions.

However, trust requires that patients believe that their provider is acting in their best interests. Once patients realize that their physicians are trying to serve two masters—the patient and the third-party payer—they will be unable to maintain the same level of trust in their providers. They are not likely to replace that trust with trust in the government agency creating federal treatment guidelines.

VI. WHAT CONGRESS SHOULD DO

Congress should revisit Medicare reimbursement in the context of enacting real Medicare reform, transforming Medicare into a system of "premium support" that resembles the Federal Employees Health Benefits Program, as originally recommended in 1999 by the majority of the National Bipartisan Commission on the Future of Medicare. With such a comprehensive reform, the current irrational national system of administrative pricing, price controls, perverse incentives, and regulatory overkill would simply disappear.

Short of comprehensive Medicare reform, Congress should fix what is broken, not make it worse. Instead of responding to the inefficiencies of central planning by instituting even more intrusive forms of central planning,

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69. Audiey C. Kao et al., *The Relationship Between Method of Physician Payment and Patient Trust*, 280 JAMA 1708, 1708-13 (1998); Anne G. Pereira & Steven D. Pearson, *Patient Attitudes Toward Physician Financial Incentives*, 161 ARCHIVES INTERNAL MED. 1313, 1313-17 (2001).

Congress should move Medicare reimbursement in the opposite direction by removing barriers to a freely functioning, consumer-driven health care market. The key driver of value in a free market is competition to meet consumer demand. Consumers must have access to full information about services and must be free to choose those services from doctors of their choice. Doctors must be free to adjust the prices of the services that they offer.

To create a market that improves quality and value within the Medicare system, Congress should take the following actions:

1. Reject pay-for-performance reimbursement proposals. Medicare pay for performance would do more to mandate compliance with centrally determined treatment processes than it would to improve the quality of care delivered to Medicare beneficiaries. Further separating patients' needs and personal preferences from the medical care that they receive would only exacerbate the long-term budget crisis. Congress should halt attempts to push Medicare into compliance-based compensation programs and instead act to implement a market-oriented payment system that drives value according to the demands of the consumer.
2. Jettison the SGR and the Medicare fee schedule and substitute annual physician payment updates and MedPAC adjustments. The complex program of price controls and central planning that governs Medicare reimbursement is a conceptually flawed system that burdens doctors with unnecessary bureaucratic obstacles, fails to control costs, and threatens seniors' access to high-quality health care.[70] This command-and-control approach to paying for health care should be replaced by a payment system that is both predictable and reflects market forces. In addition, as Representative Nancy Johnson has proposed, the SGR payment update formula should be scrapped in favor of an annual update. This update could be based on the Consumer Price Index or the Medicare Economic Index, which tracks changes in the costs of medical care. Either index would be a much more rational benchmark for physician reimbursement and would prevent the absurd predicaments of the past several years in which Congress has intervened at the last minute to save physicians from payment rate decreases. To correct for imbalances among specialties that may occur under an annual update, Congress could commission

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70. For additional details on the conceptual flaws of the current Medicare fee schedule, *see* Robert E. Moffit, *Comparable Worth for Doctors: A Severe Case of Government Malpractice*, HERITAGE FOUND. BACKGROUNDER NO. 855, Sept. 23, 1991, *available at* http://www.heritage.org/Research/HealthCare/BG855.cfm (last visited May 20, 2006); H.E. Frech III, *Overview of Policy Issues, in* REGULATING DOCTORS' FEES: COMPENSATION, BENEFITS, AND CONTROLS UNDER MEDICARE (H.E. Frech III ed., 1991).

MedPAC to recommend adjustments on the basis of market surveys in order to reflect real changes in supply and demand in the medical market.

3. Remove Medicare restrictions on balance billing and private contracting. Prices for health care services delivered to Medicare recipients are currently fixed by balance-billing restrictions. Beyond these conventional Medicare billing limitations, even if a Medicare enrollee wanted to pay out of pocket to receive more of a given service than Medicare allows (e.g., a greater number of physician visits to a nursing home), he or she could not do so without encountering other legal restrictions.[71] The most important is a legal obstacle to private contracts in Medicare, coincidentally the feature of Canada's single-payer system that was recently declared unconstitutional by the Canadian Supreme Court because it can result in increased patient suffering.[72] Medicare's restrictions on private contracts should be lifted, subject to a means test to protect the vulnerable, and provider prices should be allowed to fluctuate with positive or negative balance billings, even if the government's share is fixed through prospective payment. The Medicare Beneficiary Freedom to Contract Act (H.R. 709),[73] introduced by Representative Sam Johnson (R–TX), would remove all restrictions on private contracts between Medicare beneficiaries and health care practitioners.
4. Require price transparency of Medicare-reimbursed services. Price is the mechanism by which buyers and sellers communicate in the marketplace. Vigorous competition to provide the best quality at the best price drives superior performance. Despite the importance of price, health care consumers currently find it very difficult to acquire pricing information from providers, even when they make a concerted effort to do so. A recent survey by Towers Perrin of 1,400 employees in various health plans found that eight-five percent felt that they needed more information to make good health care decisions, specifically information about price and quality.[74] Physicians and other health care providers in

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71. As cited earlier, under Medicare law, with certain regulatory exceptions, any physician who establishes a private contract to treat a Medicare patient is prohibited from billing Medicare for any patients for two years. *Supra* note 16.

72. Jacques Chaoulli, Lecture at the Heritage Foundation (July 22, 2005) (transcript *available at* http://www.heritage.org/Research/HealthCare/hl892.cfm (last visited May 20, 2006)).

73. H.R. 709, 109th Cong. (2005).

74. Vanessa Fuhrmans, *Patients Give New Insurance Mixed Reviews*, WALL ST. J., June 14, 2005, at D1.

Medicare should be obligated to publish prices and make them available, when possible, to patients before procedures are performed.

5. Encourage private-sector development of quality information. The universal disclosure of prices will generate patient demand for better information about quality of care. If consumers, with the help of health care professionals, decide which criteria they value and which sources of information they wish to rely upon in making their decisions, the private sector will respond with patient-empowering tools that increase the capacity to make personal medical decisions. Combined with knowledge about price, these tools will enable Medicare beneficiaries to make choices that drive providers to compete for patients by using all available components of appropriate medical care, thus pushing health care to higher levels of quality and value.

VII. CONCLUSION

The current effort to change the payment system is well intentioned. Moreover, the rhetoric of "quality-based purchasing" advocates, including a reliance on evidence-based medicine, best practices, and pay for performance as methods to improve health care quality, is appealing. In reality, however, they would further bureaucratize health care.

Members of Congress need to ask themselves whether they want the government to interfere with the practice of medicine—an intervention that they statutorily prohibited when they enacted Medicare in 1965. They also need to determine whether more central planning is real reform, or whether such an approach will only further distort an already dysfunctional system, resulting in even greater difficulties for American seniors.

The negative impact of a payment system that demands compliance with standardized processes is predictable and significant. Americans not only would find themselves in the type of government-controlled health care system that they have perpetually rejected, but also would see population-based study results applied to their individual situations despite their unique health conditions, their personal values, and their doctors' experience. They would find themselves under the care of physicians restricted in their ability to exercise their best medical judgment to tailor care to their patients' specific situations and preferences. These physicians would have more incentive to check the boxes on the automatic protocol lists that generate compensation than they would to act in the best interests of their patients. This would undoubtedly decrease the level of medical innovation and weaken the doctor–patient relationship.

A new Medicare payment system should differentially reward providers who do a better job of satisfying the needs, preferences, and values of patients. However, if it rewards providers for submitting to directive protocols that

reflect the financial and political incentives of third-party bureaucrats, it is merely paying for compliance. The result will be greater distortions and inefficiencies in Medicare, further compromising quality, cost savings, and seniors' access to care.

Rather than follow this course of top-down micromanagement and artificial competition, Congress should base Medicare reimbursement reform on the free-market principles of price transparency, private contracting, and consumer choice, thus removing barriers to real competition and promoting high-quality and high-value patient-centered health care.