



Seema Verma, Administrator, Centers for Medicare & Medicaid Services,
Alex M. Azar II, Secretary
Department of Health and Human Services,
Attention: CMS-6082-NC
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator Verma and Secretary Azar,

Thank you for several comments that focus on patients:

- “Our top priority is putting patients first and empowering them to make the best decisions for themselves and their families.”
- “By reducing unnecessary paperwork, we are unleashing the most powerful force in our healthcare system for improving health outcomes: The clinician-patient relationship.”
- “We aim to increase quality of care, lower costs, improve program integrity, and make the health care system more effective, simple, and accessible.”

At the end of the day, we submit that your focus should be this: **Give Doctors a Reason to Stay.** This focus would actually be patient-centered.

Studies find an alarming number of physicians--*the only individuals trained in the practice of medicine and the art and science of differential diagnosis*--planning to leave the practice of medicine due to the bureaucratic business that it's become as a result of government programs and the imposition of managed care corporations nationwide.

In a 2016 survey by The Physicians Foundation of more than 17,200 physicians, 48 percent plan to “cut back on hours, retire, take a non-clinical job, switch to ‘concierge’ medicine or take other steps that will further limit patient access.”

Most are likely not leaving because they no longer like practicing medicine; they are likely leaving because they no longer like practicing medicine using the bureaucratic burden it's become. This is not what they spent more than a decade in training to do.

Indeed 70% of primary care physicians say they are burned out. Studies find the electronic health record to be the primary cause of that burnout. Doctors have become data clerks to answer the government's and the health plans' call for reporting, tracking, measurement, and data analytics.

In response to your eight “idea categories,” we provide the following recommendations for focusing on patients, decreasing regulatory burdens, cutting costs, and giving doctors a reason to stay in the practice of medicine.

- 1) Recognize and acknowledge that “quality” is not quantifiable. It doesn’t fit in a box no matter how many boxes in the EHR are checked by the doctor, the nurse, and the hospital staff.
- 2) One person’s “quality” is not necessarily another person’s definition of quality. Often, like beauty is in the eye of the beholder, quality is in the eye of the patient.
- 3) As the Institute of Medicine wrote in 1990:

“Defining health is difficult because of differences in what may be valued and attainable and because of the **sometimes tenuous relationship between health services and health outcomes**.

“These are not theoretical issues for those responsible for operating a program to assure quality health care. The process involves eliciting and balancing value judgments, often when legitimate interests are in conflict. Responsibilities are often shared and are therefore ambiguous.

“Even when the decisions are sound and the appropriate services are delivered with technical proficiency, poor outcomes can occur. Conversely, bad decisions or inept care will not always be followed by poor outcomes. The **quality of care cannot necessarily be judged by the outcome** for an individual, so accountability is further diffused. [emphasis added] (<https://www.ncbi.nlm.nih.gov/books/NBK235460/>)

- 4) Recognize and acknowledge that “value” is not quantifiable.
- 5) As a Harvard study found in 2018 [emphasis added]

“Then they need to consider how they will bridge the **divergent interpretations of value**. It turns out one reason there’s been such little progress in creating a value-based system is that the stakeholders in the U.S. health care system — patients, providers, hospitals, insurers, employee benefit providers, and policy makers — have **no common definition of value and don’t agree** on the mix of elements composing it (quality? service? cost? outcomes? access?).

“That’s the big takeaway of University of Utah Health’s [The State of Value in U.S. Health Care survey](#). We asked more than 5,000 patients, more than 600 physicians, and more than 500 employers who provide medical benefits across the nation how they think

about the quality, service, and cost of health care. We focused on these groups because we feel their voices have not been heard clearly enough in the value discussion.

“What we discovered is that there are **fundamental differences in how they define value** in health care and to whom they assign responsibility for achieving it.

“Value, it seems, has become a buzzword; its meaning is often unclear and shifting, depending on who’s setting the agenda. As a result, health care stakeholders, who for years thought they were driving toward a shared destination, have actually been part of a fragmented rush toward different points of the compass.” - Harvard Business Review, February 27, 2018 [emphasis added], <https://hbr.org/2018/02/we-wont-get-value-based-health-care-until-we-agree-on-what-value-means>

- 6) Recognize that government mandates and bureaucracy (e.g. EHRs, HIPAA, MIPS, MACRA, ACOs, PQRS, MOC, E&M) are driving the passion from physicians and the mission from medicine. It’s not about simplifying these rules and regulations, the agency should issues proposed rulemaking that *rescinds* the rules.
- 7) Recognize that patients have the most to lose as government regulations, advance of so-called “value-based health care” reporting requirements, “quality measurement” and EHRs change the compassionate care system drive doctors away from the bedside and to the computer, day and night, and after the bedtimes of their family.
- 8) As the Council for Accountable Physician Practices (CAPP) found in a national survey in 2017:

“The research found that patients consider their relationship with their physician the most important determinant of quality health care, to the point that they would prefer access to their own doctor over having 24/7 access to any physician.”
[\(https://accountablecaredoctors.org/integratedcoordinated-care/patients-doctors-really-want-health-care/\)](https://accountablecaredoctors.org/integratedcoordinated-care/patients-doctors-really-want-health-care/)
- 9) Recognize that many people will not use or care about the “quality” or “value” statements and stats that are created out of the bureaucratic reporting.
- 10) Years ago, the Harris Poll did a study of one million people to determine how Americans make decisions on where to access care. They found that Americans did not use “report cards.” They used word of mouth, proximity, reputation of the facility and their own personal experience with the facility.
- 11) Recognize that the current reporting requirements and regulations actually *diminish* quality because they separate the patient from the doctor, demoralized doctors, and

increasing encourage physicians to leave the practice of medicine early, reducing access to the care that the patient requires. These requirements drive medicine away from excellence, away from patient-centeredness, not toward it.

- 12) Given that much of this regulatory burden comes from federal intervention in the health care sphere, where according to States' Rights it has no authority, it behooves the department to begin to set up a system that permit Americans to extricate themselves from the dangers imposed by government-provided coverage. To that end, we advise:
- a. Conduct a pilot program that offers seniors the opportunity to take the dollars HHS provides to health plans and use them to buy their own private insurance.
 - b. Allow seniors to take an annual payment for Medicare Part B and use it as they wish, such as for Direct Primary Care or Health Sharing.
 - c. Work with the Social Security Administration to allow seniors to opt out of Medicare without losing their Social Security Retirement Benefits (i.e. delete the language in the procedural operations manual which links the two despite no Congressional authority to do so)
 - d. Allow physicians and hospitals to create and report their own list of no more than **TEN** "quality" standards, so they are meaningful to them and their patients, keeping in mind that outcomes do not necessarily reflect quality (see IOM study above).
 - e. Don't attempt to standardize and quantify that which cannot be quantified or standardized.
 - f. Review the studies mentioned above and begin there to find the answer of how to reduce paperwork, focus on patient care, and #givedoctorsareasonstostay.

Thank you for this opportunity to comment.

Please do not hesitate to contact our office with questions.

Sincerely,

Twila Brase, RN, PHN
President and Co-founder